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Medical Morality*

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I suppose it is always a bit presumptuous for a physician to stand before a group of his fellow practitioners for the purpose of giving them his views on medical morality. After all, isn't it a fact that we all well understand their importance and practice them accordingly?

To this question, I wish I could say yes. It would be nice to know that every man and woman who wears the title, Medical Doctor, also carries the disposition of an Hippocrates. Despite our best intentions, however, we physicians need constantly to look upward to the summit of ethical perfection.

Mr. Webster of dictionary fame defines ethics as a "treatise on morals." I am sure that in the minds of many of us there are slight digressions from this definition. But in the main, I believe it is acceptable.

Extending Mr. Webster's meaning into the field of medicine, we come up with something called medical morality. Frankly, I like this way of terming the subject of my discourse better than employing medical ethics.

Ethics, to me, has a vagueness about it as though you can take it or leave it. Ethics seems to be pervaded with wispiness which seems to say "It is best that you follow the honorable path; but if you don't, you will suffer only an occasional twinge of conscience."

Morality, however, stands hard and firm. Medical morality means you have obligations to follow or get out. It doesn't imply choice, only that if you do not obey the mandate your profession places upon you, you are not really a physician.

That is why I shall speak about medical morality. For the medical profession does not mince with philosophic unances when it comes to a doctor taking his patient's life or performing abortions. It accepts its traditional responsibilities which were formulated over 2400 years ago in Greece. Hippocrates, you will recall, devised a special oath which was used by all pretenders to the art of healing when they had completed their training.

Because this oath, which exemplifies the great sense of social obligation held by those Greeks, has come to us through our concepts of right and wrong we would do well to honor its provisions.

After the discontinuance of this praiseworthy vow, there is a void of information about the Oath until the Middle Ages when medical men took a similar oath. Today, in some American medical schools, the graduates are bound to declare their intentions of high medical morality by swearing to a comparable statement.

An interesting sidelight on Hippocrates reveals that though he existed, much of the work attributed to him by legend, really belongs to a number of physicians from the early Grecian days. The Hippocratic Oath, modern experts tell us, was an accumulative affair.

The same view is held concerning the ten books which bear his name. The medical ethics discussed throughout the "Precepts" and "The Law" belong to the genius of the times. And whether we regard Hippocrates as an individual or collectively, we still can appreciate the noble purpose possessed by the works bearing his name.

I have spoken of medical morality as an either-or proposition. You either follow the law or you don't. Actually, such an attitude does not reflect the best of Hippocrates. For the oath does not carry a single line of prohibition in it. Its positive approach announces simply and without inhibition that the physician's way of life is essentially noble, devoted to the practice of healing the afflicted. The good physician was one endowed by nature and seasoned in experience. His reward was fellowship in the Art, and some measure of good things in life.

At best we are good men with honorable intentions who seek to intervene between birth and death for a few score years. We recognize our human limitations, always hoping that research will bring more antidotes to disease and mental unhappiness. Generally, we try to live an upright life and carry into our profession a sense of vigilant morality.

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Last year, the convention of the American Medical Association decided upon a revised medical code of ethics. Its purpose is to protect the innocent from quacks and the like. Medical men from all income brackets and parts of the country worked together to formulate an active policy for the membership to follow. I would like to consider the major changes for a few minutes in order to bring out the fast, moral nature of medicine today. We are less concerned with basic principles applied according to the individual's discretion, as was Hippocrates, than we are with policy regulations for physicians to mutually police.

Here are the alterations:

(1) The physician is forbidden to enter into consultation with cultists of any sort if there is any implication of professional equality.

This means that aiding a chiropractor or an osteopath is ethical as long as they are not to be regarded as equals.

(2) Physicians are permitted to deliver public speeches, but the A.M.A. feels it would be wise to see that the matter discussed is first cleared through the county medical society.

(3) If a physician does not accept a consulting specialist's recommendations, he should call another consultation.

Previously, he had merely to state his reasons for changing. But it was found that the procedure often became confused with mixed perspectives emitting from the specialist and the practitioner.

(4) Under certain conditions a physician may now participate in a contract in which there is no free choice of physician.

This provision implies that contract practice in itself is not unethical. But if conditions are permitted which directly oppose the Principles of Ethics—or if they cause deterioration of the quality of medicine—the practice is definitely unethical.

(5) Physicians may not accept a patient who has been under care of another doctor for the same condition unless the former doctor has been formally dismissed.

Objections to this provision assert that it is not realistic, because no force can be brought to bear upon the public to dismiss one physician formally before taking another if there is not an inclination. And so, doctors have faced the uncomfortable position of either accepting patients of other doctors or turning them away. The latter goes heavily against his nature to want to do what he can for the alleviation of pain and for healing.

(6) Physicians are now permitted to make social calls on another doctor's patient as long as they do not discuss his health.

(7) It is every physician's duty to expose incompetent colleagues.

This poses a great problem to medical people, for who is to throw the first stone. Doctors bear about the same attitude of the United States senators and congressmen who dislike heartily to put a member on the grill for his practices. I think some feel that revenge is quite possible by either him or his friends.

(8) Physicians are now permitted to report to law enforcement officers any knowledge of illegal activity by brother practitioners.

At one time such a matter as (i.e. an abortion case) would be settled first by a committee of responsible physicians. Undoubtedly, a certain number of practitoners got out of difficulty brought on by illegal practices simply by promising good behavior.

(9) The physician no longer must counsel the public on sanitary police, public hygiene and legal medicine.

This provision was originally effected at a time when doctors were far more scarce. Today, the community is apprised of its medical needs by any number of sources, the county medical society being quite prominent.

(10) Physicians do not have to enlighten public availability on schools and prisons.

Again, this provision has grown obsolete because of the improved information sources. Though yet a staunch pillar in local society, the doctor does not need to possess the overall functions he did fifty years ago.

Medical ethics, or morality, in the modern sense extends much farther in the relationship between physicians than it did during the time of the early Greeks. Hippocrates spoke of little more than the feeling of brotherhood among the practitioners of the Art. We outline quite definitely the treatment a physician should accord his professional equal.

It is important that such a formula be spelled out deliberately, because we medical people conceive ourselves in a sort of dualistic way. First, we are brothers of the profession who primarily are concerned with bringing healthful living to humanity. Our main desire is cooperation.

With all these manifestations of the medical problem depicted in certain lines of endeavor we can easily understand the need for a more concrete code of behavior among medical people.

Second, we also are competitors. While we do not go out and hawk our good by advertising, "My bedside manner is unsurpassed," "Gallbladders asceptically removed," or "Bring me your baby and watch him gain," we do perform the same services and, therefore, must endeavor to woo patients. For this reason we need to describe an acceptable relationship in business which will be fair for all involved.

It is this very problem that currently causes debate, somewhat heated at times, between specialists and general practitioners. Many doctors feel that there is a lack of equality between themselves and the specialists. The specialist boards set rigid requirements, because as they explain, they want to protect the public

from incompetent people. Also they feel it is for the good of the profession itself.

Their critics assert that the philosophy which was held by the founders, that the public may be protected, has been altered to one of a more scientific approach. The specialist, it is said, has created his own credo, and he now seeks to create a dominant role for himself in medicine. He believes he should have certain privileges because he and his associates own special, superior faculties and character.

I believe there is something to the criticism. Certainly the medical world has tended to emphasize specialization, and it only follows that a new sort of morality will evolve. All ascendant groups, whether in politics, music or art, influence the making of new values. Otherwise they could not justify their own existence. In medicine, the same principle applies. If specialists are to be given a leading characterization, they will assume a dominating effect in medical thinking.

The general practitioner feels that justice and equality are synonymous. He wants to be given equal privileges and consideration by medical provisions. But the specialist believes equality of this sort promotes mediocrity. Why tune the medical field, he asks, to the notes of the physician low in capability? More individuality will permit quicker advancement in meeting the great problems medicine jointly faces.

The specialist has a good point. But individualism can very well lead to medical anarchy, if some sort of limiting control is not placed upon it. And that means a loss of morality. In a sense this trend is abetted by the American Medical Association's desire to give the right of decision to the county level.

History shows quite effectively how the loss of morality soon leads to punitive codes. As I have already stated, we have enough of the prohibition philosophy in our organized efforts to make medicine a high calibre. We want to retain as much as possible a morality which permits physicians to express themselves positively in the tradition of the old Greeks.

With a thorough morality conceived, we can temper this specialist versus general practitioner feud into a general understanding which assigns all parties a laudable place. Like Hippocrates, then, we can regard our calling in its true light, rather than wage dissenting battles against our professional brothers of the Art.

I have dwelled upon the relationship of physicians, because I feel it is an important aspect of medical morality, one which does not receive the attention from physicians which it deserves.

It is my earnest conviction that we must experience a constant revitalization of the principles mentioned by Hippocrates and enjoyed by the medical world ever since. We no longer associate medicine directly with religious endeavor, but we can retain a spiritual awareness of our mission. We who deal in human life also touch the Hands of God. Let us be sure our own are not stained. In each of our hearts, let us covet the words of Hippocrates who said:

"While I continue to keep this oath inviolate, may it be granted to me to enjoy life and the practice of my art, respected always by all men; but should I break through and violate this oath, may the reverse be my lot."

Treatment of Infantile Eczema

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In a discussion of infantile eczema one is most likely to be confused by half-truths and part-truths. This is a result of the lack of a definitely known etiology or etiologies. Recently I asked a pediatric allergist which etiologic factor was considered most important in infantile eczema. He answered, "None. I believe that we need a completely new approach to this problem. It seems to me that we know very little and all lines of approach eventually lead into a blind alley." Perhaps this is somewhat too pessimistic, but it is the feeling of many who have worked on this problem.

In a discussion of the immunologic concepts which underlie atopic dermatitis, Rostenberg in 1947 presented an interesting working basis with the idea of an epidermo-dermal sensitization. He postulated that an atopic person has a dual hypersensitivity—dermal and epidermal, and that these patients have an immediate wheal-type sensitivity in which antigens and antibodies react, causing an alteration in capillary permeability that results in a wheal-type reaction. Something in addition to the wheal reaction, however, is necessary for the development of a dermatitis. In other words, there seems to be some X factor in the atopic person which allows for an interaction between the separate shock structures of the epidermis and the dermis.

Many classifications of infantile eczema have been made which are of some value in considering this problem. Objective clinical classifications of this type mean more to the dermatologist who thinks in terms of a clinical picture appearing seborrheic-like or contact dermatitis-like. These clinical pictures do overlap in the atopic patient and may simulate other dermatologic conditions. In consideration of the various clinical types I would prefer to outline the basic pathology seen rather than attempt a complicated classification.

First, there occurs simple erythema which may result in scaling as is often seen on a baby's cheeks. Papules and vesicles may develop which coalesce and rupture. This produces the exudative stage which may become crusted as is seen in seborrheic types. This may also become secondarily infected and produce impetigo-like lesions. The acute picture over a period of time may produce thickening, pigmentation, and lichenification of the skin. The predominant symptom is intense itching. The most frequently involved areas include the face, scalp, ears, and extremities. Unlimited variations of the areas involved and the type of lesions seen are possible and may occur at different times in the same patient.

With this brief introduction the remainder of this discussion will be devoted to the therapeutic approaches available, and an attempt will be made to evaluate each. In the routine handling of a patient it is important to know which available therapeutic measures are of everyday practical clinical value and application.

TREATMENT OF INFANTILE ECZEMA

I. DIET: At one time it was thought eczema was a simple problem and involved merely the uncovering of a food sensitivity. It is now known that certain antigenic foods may be a contributing factor by acting as a trigger mechanism. Symptoms can often be helped or controlled—if not completely cured—by avoiding known precipitating agents.

1. MILK SUBSTITUTES: If the baby is breast fed it may be wise to wean him. The patient should be first tried on evaporated milk as it is low in lactalbumin. If this causes trouble, it is probably due to the milk caseins involved. In this case milk substitutes should be used. Examples of these include: Sobee (Mead Johnson & Company) and Mull-Soy (Borden Company). Some infants may develop a sensitivity to soy or may be unable to tolerate the product. In this case Nutramigen (Mead Johnson & Company) or a baby meat diluted to bottle consistency may be used.

2. BOILED FOODS: It is believed by some that boiling milk reduces the antigenicity of lactalbumin. It is also thought that prolonged boiling of an egg reduces the antigenicity of the albumin. However, it must not be assumed that these foods are thereby rendered entirely non-allergenic.

3. ELIMINATION AND CONTROL OF DIETS: When foods are to be added to the diet it is best to start with one simple pure cereal as oatmeal or barley. One vegetable at a time should be added, beginning with carrots or beans. One fruit at a time should be added, beginning with apples or pears. If foods are added slowly at ten day to two week intervals, sensitizing foods may be detected by an intelligent parent.

4. VITAMINS: Aqueous forms are generally best.

5. SKIN TESTS: Intradermal or scratch test (preferred) may be a useful adjunct for those who are familiar with their use and evaluation. These tests, however, are probably not

necessary since the "proof of the pudding is in the eating." Closely observed dietary routines can give satisfactory results.

II. CONTACTS: It should be similarly noted that contacts with allergenic chemicals may act as a trigger factor. Determining the offending agent and avoiding contact with it offers the most practical and best method of approach to the problem. The agent may be any known substance. Some of these, however, more commonly sensitize and should be considered first in a search for the trigger agent.

1. CHEMICALS:

(a) Baby Oils and Lotions: The perfumes and ingredients incorporated in some prepared oils and lotions may produce a contact sensitization. Mineral oil is a safe substitute.

(b) Plastics and Rubber: In our modern life plastics and rubber are common offenders when used in the manufacture of panties, toys, bibs, toilet seats, bed sheets, and other objects because they occasionally produce a contact sensitization.

(c) Insect Sprays: DDT, Pyrethrum, and other insecticides may act both as primary irritants and sensitizers.

(d) Drugs: The local application of certain drugs frequently produces local sensitization. Especially is this true with certain of the antibiotics. Of this group, penicillin and streptomycin should not be used locally. The sulfonamides are also frequent sensitizers and should not be applied to the affected area.

2. WOOL AND FEATHERS: These may be sensitizing factors but they are more frequently irritating factors. Contact with woolen blankets, clothes, toys, and feather pillows may be avoided by the substitution of cotton or linen articles.

3. DUST AND POLLENS: These may be sensitizing agents and some relief may be obtained by the use of mattress and pillow covers or foam rubber substitutes. In the nursery only washable materials should be used including linoleum rugs. Pets should be avoided. Since it is impossible to live in a "glass house" if a dust or pollen sensitivity is definitely established, vaccines may be a worth-while procedure.

4. HUMAN DANDER: Much interesting work has been done demonstrating a sensitizing factor in human dander. However, at the present time it apparently has no clinical application.

5. PATCH TESTS: These may be useful to a person who is familiar with their use and evaluation. They should be done with care and discrimination.

III. PSYCHOSOMATIC: The time invested in talking to the parent and child in explaining the importance of tension factors is well invested. The parents' insight into the necessity of a well regulated environment for the child will in many cases yield excellent results.

IV. SYSTEMIC THERAPY: Systemic therapy generally is not to be considered as specific treatment. Its purpose is to sedate and to relieve itching. One exception to this is the use of fatty acids. Some investigators have believed that a low fatty acid level in eczema patients was of etiologic significance. Therefore, the purpose of systemic fatty acid therapy was to correct this faulty metabolism.

1. ANTIHISTAMINES: These have been disappointing but they may be of some value during acute episodes. They are definitely worth a try.

2. FATTY ACIDS: In the form of lard or soy bean oil the unsaturated fatty acids have helped in the hands of some investigators. They are not recommended for routine use but may be a worth-while adjunct in resistant cases.

3. SEDATIVES: The oldest and still the best adjunct to therapy is "running sedation," either in the form of barbiturates or chloral hydrate.

4. SALICYLATES: These are worth-while, not only because of their analgesic effect but because they have a mild antipruritic effect.

5. ANTIBIOTICS OR SULFONAMIDES: These should be used internally if indicated for severe secondary infection.

V. LOCAL THERAPY: The basic principles of dermatologic therapy should be followed and varied according to whether one is treating an acute, subacute, or chronic lesion. In general all acute lesions may best be treated by compresses and bactericidal agents. Only in chronic conditions should stronger local applications be applied. Best results are usually obtained by the proper use of a few well understood therapeutic routines.

1. BATHING AND CLEANSING: It is best to avoid soap of all types in the acute stage. Starch baths or mineral oil cleansing can be done with safety. Certain special soaps as Dermolate Rx or Lowila Rx may be tried provided it is understood that these may also be irritating.

2. RESTRAINTS: Elbow splints, shirt restraints, and body straps are most important in preventing excoriation or subsequent skin damage. Elastic bandages can often be used

advantageously in making an occlusive bandage. The use of a mineral oiled plastic sheet on the mattress is useful for children who rub themselves raw on the bed covers.

3. DEBRIDEMENT: This is most important and can be done with oiled gauze or instruments. It should be repeated daily.
4. BACTERICIDAL AGENTS: For soaks and compresses potassium permanganate solution (1:4,000) may be used. For local painting, aqueous or tincture of zephiran Rx (1:1,000) or 1% gentian violet are excellent. Simple ointments with a low sensitizing index such as 3% ammoniated mercury or bacitracin are best. It is wise to avoid the local applications of drugs such as penicillin and the sulfonamides which may later be needed for internal medication.
5. TARS: Three per cent ichthammol in zinc oxide ointment is one of the mildest tar preparations that one can use. Regular crude coal tar for use in solid preparations or liquor carbonis detergens for liquid preparations are usually as efficacious as the specialized products and are cheaper and easier to obtain. They may be incorporated into simple ointment vehicles such as zinc oxide ointment, Lassar's paste, aquaphor, or carbowax. They may also be incorporated into simple liquid vehicles such as calamine liniment, Burow's solution, or simple rubbing alcohol.
6. QUINOLINES: Vioform Rx is the most popular quinoline product in this country. It may be incorporated in a lotion or ointment.
7. ANTIPRURITICS: Tars and quinolines as mentioned above are excellent. For compresses or soaks Burow's solution 1:20 or 1:40 can be used. Into any of the aforementioned vehicles ¼% menthol or ½% phenol can be incorporated.
8. X-RAY: X-ray therapy should be completely avoided in small children.

COMPLICATIONS

PYODERMAS frequently result secondarily and may occur in the form of impetigo, infectious eczematoid dermatitis or furuncles.

ECZEMA VACCINATUM may occur in a child with atopic eczema who is either vaccinated for smallpox or contacts a person recently vaccinated. They will frequently develop a generalized vaccinia. Atopic children should not be vaccinated unless the skin is completely free of lesions. A generalized vaccinia is an acute illness and may terminate fatally.

KAPOSI'S VARICELLIFORM ERUPTION is now considered a generalized cutaneous herpes simplex which may develop in the atopic child. The atopic child may acquire the herpes simplex virus from fever blisters in a parent, nurse, etc. Clinically this picture may be similar to generalized vaccinia but it is frequently more acute and the mortality rate is higher.

ACUTE GLOMERULO-NEPHRITIS may develop from a secondarily infected atopic dermatitis. Many investigators feel that ten percent of the cases can be accounted for by skin infections as frequently seen in the secondarily infected atopic dermatitis.

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Adequate Diagnosis of Vulval Lesions*

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From infancy, when gonorrheal vulvo-vaginitis must be distinguished from the irritative vulvitis of pinworm infestation, to senility, when ulcerations must be discerned as benign or malignant, female patients present the physician with the problem and the responsibility of accurately and adequately differentially diagnosing lesions of the vulva. The tabetic grandmother whose chancre thirty years ago was dismissed as a "boil on the privates," and the pitiful patient in the cachectic terminal stages of carcinoma of the vulva whose early lesion, unbiopsied, was treated with Fuadin or with Sitz baths, offer convincing argument for the need of genuine integrity in diagnosing such cases. Only thus can specific therapy be administered.

And so let us consider a methodical means of diagnosing the more common and most important lesions. First, a full history is valuable since considerable differential diagnosing can be done according to the five chief symptoms of diseases of the vulva: (1) discharge, (2) bleeding, (3) pruritis, (4) pain, (5) urinary discomfort.[1]

To go into more detail, *discharge*, when present in large quantity, usually comes from the vagina, although excessive quantities are sometimes produced by the vulva itself or by the glands which empty into it. A complaint of a greenish-yellow, creamy leucorrhea should arouse one's suspicion of acute gonorrheal infection; the color changes to white with chronicity. In the diffuse vulvitis of intertrigo and also of diabetes, the secretion is described as watery and whitish. Mycotic vulvitis is described by the patient as whitish and cheesy and hard to wash off.[1]

When the patient reports *bleeding* its exact origin must be determined and its quantity. The greatest amount of hemorrhage comes form actual trauma to the vulva or from post-operative sloughing of vulval wounds. The next largest quantity comes from carcinoma.[1]

The complaint of *pruritis* is your cue to question the patient further concerning leucorrhea and symptoms referable to the surrounding skin, the rectum and the urinary tract, and concerning such general systemic conditions as diabetes and jaundice.[1]

Pain will not be a frequent complaint since it is limited to such acute infectious processes as abscess and cellulitis, to acute open sores as produced by chancroid, and to the deeper subpubic infiltrations of malignant tumors.[1]

Urinary symptoms attend destructive processes in and about the urethra as syphilis and carcinoma and in such cases are usually manifested as incontinence, or, in deep infiltrating processes, as retention. Frequency, burning and tenesmus are characteristic of gonorrheal urethritis, while burning alone may attend diabetes or any erosive condition about the vestibulum and labia minora.[1]

Needless to say, careful study of the lesion by physical examination is essential. The following points must be noted: (1) the nature of the lesion—whether erythematous, pigmented, purulent, macular, papular, or ulcerative; and if ulcerative, the kind of base and the contour of the edges; (2) the distribution, noting especially any predilection for particular vulval structures; (3) the extent—generalized or discrete; (4) the nature of the associated exudate or discharge; (5) the presence or absence of inguinal lymphadenopathy, and if present, whether there is suppuration; (6) the effect of the vulval lesion upon the rectum.

The laboratory plays an important part in either the actual diagnosis or else the confirmation of the clinical diagnosis of vulval lesions. Almost no vulval lesion requires all the available laboratory tests for diagnosis, but almost all vulval lesions require more than one test for adequate diagnosis because of the frequency of mixed diseases superimposed one upon the other or else occurring simultaneously. This is exemplified by the coincidence of trichomonad and monilial infections, the mixed lesion of chancre and chancroid, the easily missed epidermoid carcinoma superimposed on granuloma venereum.

Here then is a logical scheme of laboratory diagnosis. In all non-ulcerative erythematous lesions of the vulva, a discharge should be sought both from the vulva and from the vagina. If present, this should be investigated for *Trichomonas vaginalis*, for yeastlike fungi, and for *Neisseria gonorrheae*.

Demonstration of the first two can be at least partially accomplished simultaneously by making a warm normal saline suspension of the discharge and examining a drop of it microscopically under low power. The trichomonads are easily recognized by their pear shape, their characteristic jerking movements, and their lashing flagellae.

In this same preparation, demonstration of mycelia is presumptive evidence of the presence of fungus belonging to the genus *Candida*, which includes the only pathogenic yeastlike inhabitants of the vagina.[2] Confirmation of the diagnosis and differentiation between the pathogenic species *Candida albicans* and the non-pathogenic species must be done by cultural methods. Since these for the most part are too complicated for routine office work, the clinician should streak slants of Sabouraud's agar or corn meal agar, either of which can be easily made, sterilized, and

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kept at room temperature in the office, and then send these inoculated slants to a suitable bacteriology laboratory by messenger or by mail. Cason and Armour[3] in 1949 introduced a screen test for identifying the *Candidas* designed to be used as an office procedure. Two plates of dextrose agar adjusted to a pH of 5.6 are used, one plain and one mixed with 1:600,000 Gentian violet. Both are streaked with the suspected vaginal discharge. Yeastlike colonies developing within 2-3 days on the plain agar but concurrently failing to develop in this time on the dye medium are tentatively classified as *Candida albicans* or *Candida stellatoides*. At the end of 4 days small lavender colonies of these two species usually appear on the dye medium. Other *Candida* species either appear on both plates within 2-3 days or else remain entirely absent from the dye medium. Cason and Armour feel that minute pyramidal lavender colonies appearing within 4 days on the dye medium are safely identified as *Candida albicans* if the culture is obtained from the vagina of a general gynecological patient with symptoms referable to mycotic vulvovaginitis, *Candida stellatoides* being encountered most frequently in pregnant women. We have gone into much detail concerning the diagnosis of fungus infection because failure to properly differentiate the various species can result in an over treated vulvovaginitis which in itself is a formidable problem.

Smears should be made from the discharge or exudate and Gram-stained for *Neisseria gonorrheae*. It must be remembered, however, that in the female a final diagnosis of gonorrheal infection cannot be made simply from finding gram-negative intracellular diplococci in smears. This affords a presumptive diagnosis; final diagnosis[4] requires growth by cultures on chocolate agar or other specific medium, then isolation of pure colonies by oxidation, and final differentiation of the gonoccoccus from related organisms by fermentation with sucrose, maltose, and dextrose.

For the physician situated far from a laboratory, gonococcus cultures present a problem in that the plates must be streaked within 2-3 hours of obtaining the specimen and at present there is no way of mailing cultures as can be done with fungus. In such cases, when cultures are indicated, it would seem wise to refer the patient directly to the laboratory. On the other hand, if the laboratory can be reached within the time limit, the specimen is probably best transported on a cotton swab immersed and stoppered in a culture tube containing Proteose Peptone No. 3.

Non-ulcerative, erythematous lesions warrant a test for glycosuria, and, when pigmented, a biopsy to distinguish between the benign lesion vitiligo and the precancerous lesion leukoplakia. If there is any serum to be obtained it should be subjected to darkfield examination since erythema is sometimes the earliest pre-erosive lesion of syphilis.

Ulcerative lesions of the vulva frequently bear an ominous significance and must be interpreted with the greatest integrity. Their diagnosis is facilitated by selectively employing the following procedures: Directly from the lesion—(1) darkfield examination for *Treponema pallida*, (2) biopsy and cytological study for carcinoma, (3) smear and biopsy for the Donovan bodies of granuloma venereum, (4) culture for the Ducrey bacillus of chancroid. Skin tests—(1) the Frei test for lymphopathia venereum, (2) the bacillary antigen[5] skin test for chancroid. Blood tests—(1) complement-fixation test for lymphopathia venereum, (2) serological tests for syphilis.

As mentioned previously, almost no disease of the vulva would require all these aids for diagnosis. In private practice it is obviously desirable to require no more than the essential laboratory work. We consider the very minimum compatible with adequate diagnosing of any ulcerative lesion of the vulva to include: serological tests for syphilis, darkfield examination, biopsy, and the Frei test. These four procedures will clarify the differentiation of syphilis, granuloma venereum, lymphopathia venereum, and cancer. Furthermore, they fall within the capacity of every clinician whether he is near a large laboratory or not, since with experience darkfield examination and skin testing can be performed and interpreted in the office, and everyone is familiar with obtaining blood by venapuncture and tissue by punch biopsy in the office and mailing the respective specimens to appropriate laboratories. Other procedures are employed according to the dictates of one's clinical judgment.

The manner in which specimens are collected and dispatched to the laboratory for diagnosis may mean the difference between whether positive and negative reports are valid or not. In making a darkfield examination it is important that the lesion be cleansed of all contaminants and that clear serum be obtained from it by squeezing its base and rubbing its surface briskly with gauze sponges. Punch biopsies for Donovan bodies and for carcinoma should be taken from multiple sites, should be fairly deep, and should include a margin of healthy tissue whenever possible.

Material for cytological study may be collected in several ways. At this institution we have found that with lesions reasonably clean and free from secondary infection, the Papanicolaou technique is quite satisfactory. Important points are to spread adequate material evenly on the slides and immerse them immediately in the ether-alcohol solution before they begin to dry.If these are to be mailed, the slides are fixed in this solution for at least 15 minutes, removed and allowed to drain of excess fluid, overlayered with a thin coating of glycerin, and covered with a clean dry slide. Achenbach, Johnstone, and Hertig[6] report a modification of the Papanicolaou stain with which glycerin is not needed in preparation for mailing. While these variations exist, clinicians should consult their pathologists concerning the method of preparation applicable to the method of staining to be used. We have also found that with dirty, bloody, or grossly

secondarily infected lesions, collection of material by the Gladstone[7] technique with squares of Onkosponge No. 1 gives the best results. Our adaptation is to grasp the half-inch square sponge in the center of one of its flat surfaces, "scrub" the lesion with the opposite flat surface until thoroughly saturated, and then reverse sides so that the entire sponge is saturated. One of the advantages of this "sponge biopsy" is that for fixing, mailing, embedding, sectioning, and staining, it is handled as an ordinary tissue biopsy.

This paper has presented an approach to the diagnosis of vulval lesions. We conclude with one plea concerning therapy: Do not begin treatment on any vulval lesion until diagnosis has been established!

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Observations on the Effects of Priodax on Blood Sugar and Non-Protein Nitrogen

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CHEMICAL PROPERTIES AND ACTION

Priodax, beta-(4-hydroxy-3,5-diiophenyl)-alpha-phenyl-propionic acid, is a stable organic compound containing 51.38% iodine firmly bound. It is not a phenolphthalein deriverative. It is practically insoluble in water, but soluble in alkali hydroxides, carbonates and bicarbonates. Priodax is supplied in .5 Gm. tablets and the usual dose given for cholecystography is six tablets, twelve to fifteen hours before examination. Physiologically, this substance is selectively excreted with the bile, with subsequent gall bladder concentration to render the organ suitable for x-ray. It is also claimed to serve as an index for the functional biliary system.

TOXICITY

Priodax tablets are fairly well tolerated by patients. Diarrhea is almost a constant finding as well as intestinal cramps. In certain batches of the dye, one finds the instance of side reaction greater than others. Vomiting is occasionally encountered and at times becomes so severe until parenteral fluids become necessary. Priodax is contraindicated in acute abdominal conditions, where a sensitivity to iodides is suspected and, in acute nephritis and uremia or in any condition with poor renal function. Albuminuria has not been reported although it no doubt actually exists. When the urine is tested with solutions such as Robert's Reagent, one finds an intense white precipitate due to the reaction of the sulfosalicylic acid present in the reagent with the excreted Priodax. Aqueous solutions of Priodax brought to a boil with acetic acid yield no precipitate. Since a considerable portion of Priodax is excreted in the urine, false positive reactions to albumin will result with the usual albumin test. Red blood cells and casts are occasionally encountered. These findings usually disappear within twenty-four to forty-eight hours following the administration of the dye.

PREVIOUS REPORTS

Rossien[1] reports little or no change in the blood sugar and N.P.N. following the administration of Priodax in the indicated dosages. In his study there was a slight increase in the blood sugar in ten cases and a decrease in four. The N.P.N. was slightly increased in four patients and decreased in ten. The average blood sugar before the administration of the dye was 104.7 mgm. and afterwards 106.7. The N.P.N. was 36.1 mgm. before and 35.6 afterwards. These studies were presumably done on hospitalized patients.

METHOD OF STUDY AND RESULTS

In our observation on a series of nine patients, three of which had definite gall bladder pathology, we obtained slightly higher figures. These studies were made on out patients. A fasting N.P.N. and blood sugar was done twenty-four hours before the administration of the dye. The patient was given six tablets to be taken with a fat free meal at six p. m. the evening before the study. From then until nine a. m. the following morning they were allowed nothing but water. At nine a. m. blood was drawn from the vein. The method of Folin and Wu was used for determining the blood sugar and N.P.N. All studies were done by the same technician and the results read with a Leitz Photo Electric Colorimeter. The average fasting blood sugar was 115 mgm. and N.P.N. 36 mgm. After the administration of the dye the average blood sugar was 153 mgm. and the N.P.N. 39 mgm. The average increase in the blood sugar following the administration of the dye was 38 mgm. and the N.P.N. 8. A break down of these cases is shown in Fig. 1. In several cases which showed an exceptional rise in the blood sugar a second determination was done twenty-four hours later. These had returned to their normal limits indicating that the dye was possibly the precipitating cause.

SUMMARY

Nine cases were presented to show the effect of Priodax on the blood sugar and N.P.N. These showed an average increase in the blood sugar of 38 mgms. and in the N.P.N. of 8. In several of these patients with unusually high blood sugars, determinations were made the following morning and showed normal values.

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FIGURE 1

FASTING

	NO PRIODAX		PRIODAX 6 tablets		
	N.P.N.	Blood Sugar	N.P.N.	Blood Sugar	
1	31	123	45.5	208	Stones in gall bladder
2	34	117	48.5	198	Normal
3	28	98	30	113	Normal
4	35.5	90	41	108	Normal
5	31	147	34.5	123	Normal
6	27	95	29	103	Normal
7	21.5	130	37.5	153	Stones in gall bladder
8	39.5	113	41	130	Poor function of gall bladder
9	32	118	42.5	138	Normal
Average	31	115	39	153	

Heredity in Disease

A REVIEW

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According to Mendel's law, when two varieties of plants, differing from each other in one characteristic, are crossed, the hybrids preserve, for the greater part, the peculiarity of one or the other parent. The characteristic which persists is called the dominate; that which tends to disappear is called the recessive. Mendelian recessive traits may be transmitted in certain conditions of disease, among them, in chondrodystrophia foetalis, hereditary icterus, the remarkable form of fatal familial pitting edema described by Edgeworth, Milroy's disease, angioneurotic edema, hemophilia, hereditary spastic paraplegia, and others.

Fatal Familial Pitting Edema.—Edgeworth has described a remarkable form of fatal familial pitting edema occurring in apparently healthy children who are born at full term. The first case was that of a male who remained well until six weeks of age when he developed diarrhea and generalized edema, dying at the age of seven weeks. The second child, a female, began to have diarrhea when one week old, became generally edematous one week later and died in convulsions at the age of nine weeks. The third child, a male, had slight diarrhea toward the end of the third month, then became edematous over the entire body and died at the age of five months. The fourth child, a male, was well until one month of age when he developed diarrhea followed two weeks later by edema, first of the left hand, then of the face and subsequently over the whole body, death occurring soon after. The fifth child was observed at two and a half years of age and remained apparently healthy. The sixth child, a female, was healthy until the age of three months when she began to suffer from slight diarrhea together with swelling around the left eye followed by edema of both legs and hands; shortly thereafter death occurred. Two of the five children dead of this disease were examined post mortem but no evidence of nephritis was found in either one. In other words, five of six children born of healthy parents developed subcutaneous pitting edema at ages varying from one to fifteen weeks, death occurring after a period of from one to sixteen weeks. The disease described by Edgeworth is to be sharply distinguished from so-called sclerema or edema neonatorum. The latter affection occurs practically always in enfeebled premature infants. The edema, which pits with difficulty, almost always commences in the lower extremity, spreading upwards as it diminishes below, leaving the skin thin, dry and wrinkled. The temperature in these infants is often subnormal and death occurs within two to twelve days after birth.

Milroy's Disease.—Persistent hereditary edema, or Milroy's disease, usually occurs in families of neuropathic taint. In Milroy's original series 22 persons were affected among 97 individuals in six generations while, in the Wherrell family, the affection, which was present for more than sixty years, occurred in 13 of 42 persons in five generations. As a rule, the lower limbs are affected and the edema is of the non-pitting variety. Acute episodes may occur in which the affected limb becomes tense, swollen and reddish attended by such symptoms as rigors, fever, abdominal pain and vomiting. The diagnosis of Milroy's disease depends upon (a) the absence of all other recognizable causes of edema; (b) the familial and hereditary character of the disease and its association with

neuroses in the affected individual or in other members of the same family; (c) its extreme chronicity, the affection sometimes dating from birth and lasting for the remainder of life, at whatever period it starts; (d) the sharply defined boundary of the swelling and the tendency to affect segments of limbs rather than to follow the law of gravity, as in ordinary edema; for example, the leg may be edematous and the foot normal and (e) the tendency to produce hyperplastic changes in the skin and subcutaneous tissues of the affected limb, as in elephantiasis.

At Bellevue Hospital a twenty-four year old female patient was observed both of whose upper eyelids presented circumscribed, solid, non-pitting edema that had been present for seven years. In another case a boy of fourteen years presented solid edema of the upper lip that had persisted for a period of four years. In neither history was there anything to indicate that the affection was familial and whether it is to be regarded as a variety of Milroy's edema is doubtful (Symmers).

Angioneurotic Edema. — Angioneurotic edema (Quincke's disease) is an hereditary affection characterized by the occurrence of edematous swellings usually limited in extent and of short duration, sometimes associated with gastrointestinal symptoms. The edema appears suddenly and most frequently involves the eyelid or the lips or the cheek, although frequently the hands, the legs or the throat may be affected. In some instances there is a remarkable periodicity in the appearance of the edema, the attack coming on every day at much the same hour. In a family whose history was recorded by Osler five generations were affected, including twenty-two members, in two of whom death occurred as a result of laryngeal involvement. The gastrointestinal episodes consist of colic, pain, nausea and even vomiting. Sometimes the colic is of such intensity as to require morphine. The disease has affinities with urticaria, the giant form of which is probably the same affection. The condition described by Perrin as intermittent hydrathrosis is regarded by some as the joint equivalent of angioneurotic edema. It is characterized by periodic swelling of one or several joints at intervals of weeks, sometimes months, the swelling occurring with great rapidity, occasionally accompanied by a sensation of "water rushing into the joint."

Familial Icterus.—Jaundice of the new born, or icterus neonatorum, occurs as a mild or physiologic process, or in a form that may be severe, even fatal. The mild variety is commonest in foundling hospitals where it occurs in from thirty to seventy percent of all new born babies. Jaundice appears usually on the first or second day, is of moderate intensity and disappears within two weeks. Some have attributed it to stasis of bile in the smaller ducts following compression by the distended radicles of the portal vein. Others believe that it is due to the rapid destruction of red blood cells that sometimes occurs soon after birth. The severe form of icterus in the new born may depend on congenital syphilitic hepatitis, on absence of the common or hepatic duct, or on pyelophlebitis of the umbilical vein.

A familial form of icterus occurred in the remarkable group described by Glaister, in which a woman had eight children, six of whom died of jaundice shortly after birth; the mother of this woman had twelve children, all of whom became icteric shortly after birth, and a brother was the father of several children who also were jaundiced soon after birth. Minkowski recorded eight cases of acholuric icterus in three generations. Many cases of the Minkowski type have since been recorded and nearly all of them were in familial groups although both Chauffard and Osler mentioned examples without an hereditary basis. Finally, there are cases with marked enlargement of the liver, splenomegaly, anemia, dwarfism and slight jaundice that have been described in two or more members of the same family under the designation of Hanot's hypertrophic cirrhosis.

Hemophilia.—Hemophilia is an hereditary disease which is confined to the male sex and is characterized by immoderate hemorrhage occurring both in childhood and in adult life. The disease is transmitted through females but they themselves are not hemophiliacs. The cardinal symptom is an inherited tendency in males to bleed after injuries which would be of no moment in a normal person, the blood trickling until death occurs or there is spontaneous arrest. Bleeding may be external, internal or into joints. Although a majority of cases are traceable to trauma, spontaneous hemorrhages sometimes occur.

Amaurotic Family Idiocy.—In the majority of cases hereditary spastic paraplegia begins in children between the seventh and fifteenth years, affecting two or more members of the same family. It starts in the legs with the characteristic spastic gait and all the features of an ordinary spinal paralysis, later extending to the arms with or without such symptoms of multiple sclerosis as volitional tremor, nystagmus and scanning speech. A remarkable form of infantile spastic paraplegia has been described by Sachs and Tay and is now widely known under the eponym of Tay-Sachs' disease. It is characterized by psychic disturbances which appear in the first or second year of life and progress to total idiocy, by paresis and ultimately complete flaccid or spastic paralysis of the extremities, by increased or decreased tendon reflexes and by partial, followed by total blindness due to retinal atrophy preceded by changes in the macula. The latter were described by Warren Tay, an English ophthalmologist, and are known as the cherry-red macula. The choroid appears as a brilliant red spot through the fovea centralis surrounded by a contrasting white circle. In this form of infantile paralysis death usually occurs before the end of the second year. In 27 cases of amaurotic family idiocy originally collected by Sachs, 17 occurred in six families and all

were in Hebrews. Of 86 cases since reviewed by Heveroch 61 (71%) were in Jews.

Diabetes Mellitus.—In diabetes mellitus hereditary influences play an important role and cases are on record of its occurrence in many members of the same family. Naunyn, for example, obtained a family history in 35 out of 201 cases (17%). Semitic peoples seem especially prone to it; one-fourth of Freirichs' patients were Hebrews.

Chondrodystrophia Foetalis. — That the lesion variously known as chondrodystrophia foetalis, achondroplasia, fetal rickets and the like, is of great antiquity is attested by the numerous instances in which the disease finds representation among pottery and statuary of the ancients. The models of the Egyptian gods, Ptah and Bes, to be found in the Louvre, the existing statuette in caricature of the Roman Emperor Caracalla, the figures of the gladiator dwarfs in the service of the Emperor Domitian, as well as the subjects of certain paintings, notably by Velasquez, among them that of Sebastiano de Moro, a dwarf of the Spanish Court, are all recognizable examples of fetal chondrodystrophy. Historical interest attaches to the statement that, in the sixteenth century, Catherine de Medici revived the ancient custom of according gnome-like creatures a position in the social firmament of the Court, where they enjoyed unusual latitude of speech and action in the capacity of jesters, and emulating the Emperor Heliogabalus, she sought even further to gratify her perverted taste by celebrating marriages between dwarfs with the purpose of perpetuating a stunted race comparable to the ethnic dwarfs of fact and fable. A survival of the same perversion consists in exploiting the chondrodystrophic dwarf in the circus of today that his deformed body may be held up to gibe, ridicule or vulgar curiosity. On the other hand, numbers of characters distinguished by action or intellect are known or are reputed to have been the victims of fetal chondrodystrophy, among them the author of Aesop's Fables; Philetas of Cos, tutor of Ptolemy Philadelphus and a poet and grammarian of renown; Licinius Calvus, a rhetorician; Atilla, King of the Huns; Wladislaus, called "Cubitalis," King of Poland, and noted for intelligence and military sagacity, and others of like account.

From an etiologic standpoint chondrodystrophia foetalis is scarcely less obscure than it was in the beginning and of the several factors which have been invoked to explain its origin none appears to be worthy of serious consideration other than that the condition is always congenital, completing its development in the first few weeks of intrauterine existence, that it preponderates in the female sex, and that it sometimes presents familial characteristics. In the latter connection Rischbieth, who has contributed an admirable paper to the eugenics of dwarfism, states that, while a chondrodystrophic parent usually begets normal children, heredity not uncommonly displays itself in the shape of a deformed progeny. The pathogenesis is no less conjectural for having been referred to various types of intoxication, including infections and placental and glandular perversions.

The first really adequate contribution to the pathology of chondrodystrophia foetalis was made by Mueller, who observed the disease in certain forms of cattle and identified the changes with those previously noted in the human skeleton. Mueller's observations have since been extended to include certain short-limbed domestic animals, more particularly the dachshund, bull dog, Pekinese spaniel and Aberdeen terrier, but observation has shown that the likeness between them and the subjects of chondrodystrophia foetalis is fancied rather than real and that these animals merely typify combinations of different racial peculiarities brought about by artificial selection.

Individuals of the chondrodystrophic type, the majority of whom are still-born or die young, are deformed in certain bones which are conceived in cartilage and whose scheme of development is completed before the eleventh week of embryonal life; that is to say, the osseous complements of the base of the skull and the pelvis, the ribs and the long bones of the extremities. Consequently the child at birth is greatly abbreviated in stature, the head is large and the extremities, which may be crooked, are symmetrically shortened and thickened, varying between micromelia and phocomelia, and the cartilaginous termini are enlarged and nodular. The finger tips, which normally reach to the level of the upper third of the thigh, rest at the crest of the ilium or shortly below it. The hands are broad and pudgy and the middle digit is shortened. The fingers are roughly conical in outline and separate in pairs, combining with the outstretched thumb to form the main en trident of the French. The face is relatively small, the nose depressed at the root and the frontal eminences are exaggerated. These features unite with the large cranial vault to lend a pyriform outline to the face. The trunk is usually well formed and of normal size, although the abdomen frequently is protuberant. The skin, which develops out of proportion to the growth of the bones, is thrown into folds, especially over the joints and corresponding to the normal creases. It is often waxy in appearance and the subdermal tissues may be edematous or excessively infiltrated by fat. In those who attain adult life these characteristics are preserved, but as development proceeds the individual is endowed with muscular strength, sexual vigor and a degree of intelligence often noticeably in excess of the average. In addition to alterations in the bony skeleton, certain numbers of chondrodystrophic individuals present external signs that are suggestive of cretinism; so much so, indeed, that some observers have proclaimed that chondrodystrophia foetalis and infantile myxedema are manifestations of the same fundamental disorder, or, at all events, that the two conditions are closely related. The relationship of chondrodystrophia foetalis to cretinism was originally

insisted on by Mueller and by Eberth, both of whom pointed out that the so-called bull dog calf presents cretinoid appearances. Some years later Leblanc noted the association of chondrodystrophia foetalis and myxedema in calves and attempted to implicate the thyroid gland as the causative factor in the production of both the skeletal and myxomatous changes. It remained for Seligmann to demonstrate tangible changes in the thyroid gland of the bull dog calf and to establish the coexistence, in cattle at least, of chondrodystrophia foetalis and congenital myxedema. Seligmann examined specimens of Dexter calves born in Kerry. In all of them the skin was thick and coarse and the subcutaneous tissues were myxomatous. The head was large and brachycephalic, the forehead bulging and the nose despressed. The tongue was large and protruded from the half-open mouth. All the limbs were extremely reduced in length and their bones were stunted and provided with thickened, deformed, softened cartilages. In every instance the thyroid was irregularly lobulated and, on microscopic examination, the alveolar architecture was scarcely recognizable and the cells were arranged in clumps or branching columns. Colloid was practically absent and the gland was abnormally well vascularized.

As to the influence of the thyroid in the production or modification of chondrodystrophic foetalis in human beings, there is little to be found in the literature. Kaufmann, Legry and Regnault, and others have submitted the thyroid to histologic examination with negative results. In the same way Marie, Cestan and Christopher have failed to note beneficial effects from the administration of thyroidin and thyroid extract. Symmers and Wallace have described a form of chondrodystrophia foetalis in which, in addition to the changes in the osseous system, there are modifications in the soft tissues that are attributable to pathologic defects in the thyroid gland. The modifications consist of thickening of the lips, cheeks and eyelids, the wings of the nostrils and the lobes of the ear, macroglossia, hypertrophied vulvae and myxomatous transformation of the subcutaneous and certain deep connective tissues, all of which, when combined with the large head and frog-like expression, the protuberant abdomen, prominent skin folds and pudgy extremities, fulfill the requirements for the diagnosis of cretinism. In the cretinistic variety of chondrodystrophia foetalis, the pathologic changes in the thyroid gland are those of a chronic productive inflammatory process resulting in replacement of follicles and diminution in the amount of colloid material.

CANCER

Edited by HENRY W. MAYO, JR., M.D., Charleston, S. C.

CARCINOMA OF THE THYROID

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While carcinomas of the thyroid gland comprise less than 1 per cent of human cancer, their variable clinical behavior and complete unpredictability as to prognosis make them one of the most interesting types of cancer. It is now generally accepted that thyroid cancer seldom develops in other than a pre-existing diseased gland. As Lahey and Hare[1] have recently shown, 10.04 per cent of discrete adenomas are malignant when examined histologically. This fact is emphasized by a quotation from Ward and Hendrick:[2] "It is definitely established that pre-existing benign adenoma is the most important known etiological factor in the development of thyroid malignancy." It is estimated that at least 80 per cent of thyroid malignancies arise in fetal adenomas. Fetal adenomas are now generally accepted as being true neoplasms. Most other thyroid malignancies arise in the common nodular goiter.

During the past fourteen years (January, 1938 through December, 1950), twenty-one cases of histologically proven thyroid cancers have been treated at Roper Hospital, Charleston, South Carolina. Sixteen of these were women and five were men; twelve were colored and nine white. The youngest was 26 and the oldest 88 when diagnosed. Although there were no children in this series of cases, carcinoma of the thyroid does occur in children. Dailey and Lindsay[3] reported twenty-three cases of thyroid malignancy in patients under 20 years of age. Ward, Hendrick and Chambers,[4] in their series of 112 thyroid cancers, found five under 20 years of age, and the youngest was 4 years old. Fortunately, as Hare and Newcomb[5] showed, the prognosis in these cases can be favorable.

Warren's[6] modification of Graham's classification of thyroid tumors has been used in this series. This classification is practical, both clinically and histologically. In many instances the pathologic report of thyroid cancer comes as a surprise to the clinician, and thirteen of the cases in this series were operated upon for what was thought to be a benign lesion of the thyroid, only to have carcinoma reported by the pathologist. Frozen section examination in the diagnosis of carcinoma of the thyroid gland is not applicable. At operation, the diagnosis of malignancy can be made from the gross appearance, only in advanced cases, and then not always without difficulty.

The tumors of low-grade malignancy are the pap-

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illary cystadenomas and the adenomas with or without intact capsules, but with blood vessel invasion. Moderately active is the papillary adenocarcinoma which commonly arises from pre-existing adenomas. These tumors are characterized by papillary projections covered with cuboidal or polyhedral cells. These projections may lack well defined cell boundaries. Less common tumors of moderate activity are the Hurthle cell and alveolar adenocarcinomas. The carcinoma simplex and giant cell carcinomas usually indicate a malignancy of high grade.

The first and almost constant symptom presented is the recognition of a fullness or new growth of the neck. Twelve patients in this series complained of a mass or swelling in the neck as the first symptom, and all were aware of a new growth in the neck. Although aware of these changes, they waited from two months to as long as ten years before seeking medical advice. In all cases the patients listed the presence of a mass among their complaints while five patients had no other complaint than a mass in the neck. Less common complaints were weakness, weight loss, dysphagia, dyspnea, neck pain, hoarseness and nervousness. Most of these symptoms were associated with cases having advanced tumors. In the patients with multiple nodular goiter, mild symptoms of hyperthyroidism were present.

In every case, upon careful examination of the neck, there was found some form of thyroid enlargement. In only three cases was bilateral multinodular goiter present. In eight cases growths were far advanced, consisting of hard, fixed tumors in the region of the thyroid gland, and often extending into the supraclavicular spaces and posterior triangles of the neck. Emphasis is again placed upon the necessity of careful examination. By diligent and systematic digital palpation of the neck, nodules of very small diameter can be found. They are usually firm but may be cystic, freely movable or attached to neighboring structures, such as the trachea or esophagus, and in some cases may invade blood vessels or nerves. This extension and attachment explains the hoarseness, dyspnea, and dysphagia. These findings commonly are associated with more advanced tumors.

Other physical signs are associated with more advanced stages of malignancy. Five patients had dyspnea due to pressure on the trachea; three had dysphagia because of tumor pressing on the esophagus; and two had hoarseness due to recurrent laryngeal nerve involvement. In very advanced cases there may be distention of the neck veins and local metastases, with enlargement of the regional lymph nodes. Marked weight loss, pathologic fractures and lung and cerebral metastases are very late findings.

On account of the possibility of malignancy, isolated nodules of the thyroid should be removed intact with a good margin of surrounding thyroid tissue. In those cases in which the postoperative diagnosis of thyroid cancer is made in a discrete adenoma, subsequent total removal of the involved lobe is urgently indicated. Roentgen therapy should follow the surgical excision.

In tumors where growth has exceeded the limits of the thyroid capsule, it is most likely that regional lymphatics are involved. These cases require complete excision of the involved lobe, the thyroid isthmus, and subtotal removal of the opposite lobe. It is our opinion that a radical neck dissection on the involved side should accompany the thyroidectomy. Roentgen therapy should follow this surgical dissection and extirpation.

Even far advanced cases with known metastases often can be offered relief from pain and discomfort. Subtotal excision of the tumor, especially for relief of tracheal decompression, can give complete relief from dyspnea. Roentgen therapy will often retard local growth to a marked degree, and should always be used after surgery.

Radioactive iodine^{131} has been used to treat six different cases in this series. There were five females and one male. All the females were past child bearing age, and we feel that I^{131} should be limited in its use to women unlikely to become pregnant. This is because the ovum might be exposed to radiation. Each case was given a test dose of 100 microcuries before therapeutic doses were given. In these cases the dosage varied from 4 to 32 millicuries of I^{131}. In one case with a pathologic fracture of the femur, there was great subjective improvement, and the patient was able to walk well with crutches; however, follow-up x-rays have shown little change in the fracture. In our experience, radioactive I^{131} is effective chiefly where metastases have occurred. For I^{131} to be effective the thyroid tissue must be actively functioning and need iodine. In carcinoma of the thyroid there is usually poorly functioning gland present. It is for this reason that we expect only limited value from I^{131} in the treatment of thyroid cancer.

Since establishing a histologic diagnosis, five patients have lived over five years. Six patients, from five months to eight years since initial treatment, are free of recurrence at this time. None of the twenty-one patients received preoperative roentgen therapy, but seven did have later roentgen therapy.

SUMMARY

During a fourteen year period ending December, 1950, twenty-one cases of carcinoma of the thyroid were seen in this clinic. An analysis of these cases has been carried out. The most favorable prognosis was found in cases not suspected of being malignant at the time of removal. Emphasis has been given to the importance of prompt excision of discrete thyroid adenomas. It is felt that radioactive I^{131} is of only limited value in the treatment of carcinoma of the thyroid.

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THE PRESIDENT'S PAGE

From time to time, your president will attempt to discuss on this page, which the editor has kindly assigned to him, matters of greater or less interest to the members of the association. An attempt will be made to make the discussions informative. However, no doubt he will deal at times with controversial subjects. At such times, he will try to state clearly his opinion, not with the intention of molding opinion, but rather to arouse thinking on the part of the reader, and to stimulate him to form opinions of his own.

There has been considerable criticism with regard to how the affairs of the Association have been run. No doubt some of this has been justified. Furthermore, although the management of the association has been modeled on a representative type of government, with duly elected representatives who are, or should be, responsive to the will of those represented, it has happened with us, as is true with units of our civil government, that the members at large have not always chosen their representatives well, and that their representatives have not been given an opportunity to learn of the views of their constituents.

Perhaps more criticism has been directed toward the council than toward either the officers or the house of delegates. Although the councilors are elected by the house of delegates, by custom they are nominated by delegates from their respective districts, and also by custom, the first man nominated is the man elected.

Although the councilors are association officers, they are also the representatives of the members in their respective districts. They should be selected with care, and they should be informed of views and wishes of the members in their districts. There is no reason why they should not be instructed by resolutions and discussions in the various district meetings.

As I have sat as a member of council during the past year, I have been impressed with the earnestness of its members, the absence of mass action, and the sense of responsibility which each man has had. No doubt council has made mistakes. No doubt, at times, their actions have not reflected the will of the members, but a study of the minutes of the house of delegates for several years past will show that almost every progressive step that has been made by the association has been initiated in council, and further, that very few recommendations made by council have been rejected by the house of delegates.

Government by council and the house of delegates is representative government. However, it is not in fact democratic government. Much of our legislation is not truly democratic. It approaches it when resolutions introduced in the house are deferred for later action so that they might be studied. This is always true of amendments to the constitution, and is frequently true of other important proposals. However, such deferment is of little value, if the members do not avail themselves of the opportunity to study the proposals and do not voice an opinion concerning them. When they do not do so, they really have no just reason to complain of the action taken nor to charge ring or clique rule.

On another page in *The Journal* is a detailed proposal of certain changes I recommended in my address to the house in May. Its objectives are to make action by the house on important and controversial matters more democratic, to give an opportunity for every member of the association, in contradistinction to every delegate, an opportunity to express an opinion; to make the deliberations of the house more orderly and less hurried; to institute a system of reference committees, which will hold hearings on matters referred to them and which will attempt to reflect the will of the members of the association rather than the opinions of either the delegate of the committee proposing the resolution or that of the committee itself. I believe the proposals, if adopted, will accomplish those objectives, I believe that they will prove pleasant to work under, and I believe that they should be given a trial at the annual meeting next year. One newly elected councilor said, when he saw them, that they would effect the most progressive step that the association has taken in years.

Perhaps the chief objection to them is that their adoption will extend the length of the annual meeting one-half day, which will, for most members attending, mean that they will not return home until Friday morning. The annual banquet would be Thursday night. A councilor, if he attended the entire meeting, would be away from his practice five days; a delegate, one day less; and a member who was interested in the business to be transacted and the scientific program would be away four days. However, that is not too long for an annual meeting. Furthermore, the requirement, re-enacted in May, that all committee reports, committee recommendations and resolutions should be published in *The Journal* before the meeting, will make it possible for a member to know beforehand whether or not he wished to be heard on any matter to be taken up, and if it were impossible for him to be present, he would have an opportunity to discuss impending legislation with his delegates and his councilor.

Please study this proposal. Discuss it, if you will, in your county or your district societies, and let your councilor know how you react to it.

J. Decherd Guess

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price ---------- Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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JULY, 1951

THE COUNCIL

During the past year there has been considerable discussion, and at times criticism, of the Council of our Association. A discussion of the Council—its rights and duties under our constitution, its functions, its recent activities—would seem in order.

Article VI of our Constitution reads:

The Council shall consist of the Councilors, and the President, the Vice-President, the President-Elect, the delegates to the American Medical Association, and the Secretary of the Association, and the President of the S. C. Medical Service Plan.

Article VII of the By-laws outlines the duties of Council, as follows:

Section 1. The Council shall meet daily during the Annual Session and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall elect a Chairman, Vice-Chairman, and a Clerk, who in the absence of the Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. Five members shall constitute a quorum.

Section 2. The Council shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a component society, upon which an appeal is taken from the decision of an individual Councilor. An appeal from the decision of the Council may be taken to the House of Delegates.

Section 3. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 4. The Council shall provide for and superintend the publication of the Journal of this Association and for such other publications as may be necessary. The Council shall appoint the Editor and such assistants as may be deemed necessary. The salary of the Editor shall be fixed by the Council.

Section 5. The Council shall receive the annual audit of the Treasurer and the report of the Secretary and of the Editor and other agents of the Association and shall present a statement of the same in its annual report to the House of Delegates. At its annual meeting, the Council shall adopt a financial budget for the coming year.

Section 6. Between the regular meetings of the House of Delegates, the Council shall serve as the Executive Committee of the Association. In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election. In the event that the President and Vice President both die, or resign, or are removed from office, the Chairman of the Council shall assume the Presidency until the President-Elect is duly installed into office at the next Annual Session.

In brief, the functions of the Council are (a) to serve as the executive committee of the Association and to conduct its affairs between meetings of the House of Delegates, (b) to serve as the Board of Censors of the Association, (c) to supervise and be responsible for the financial affairs of the Association, and (d) to provide for the publication of our Journal and to elect the Editor. A further function, assigned to it by the House of Delegates but not incorporated into the Constitution, was to put our Ten Point Program into effect and to elect a Business Manager for the Association.

It was our privilege to first sit as a member of Council twelve years ago. At that time there was an annual and occasionally one additional meeting of the body during the year. The sessions were devoted largely to a hearing from each member of the Council as to the activities in his district and to a general discussion of medical problems which existed in the state and toward possible plans for their solution which could be presented to the House of Delegates for action.

In 1941, the Council suddenly found itself faced with a severe emergency. The clouds of war were imminent and a large number of physicians were volunteering for service with resulting depletion of medical care for the people of the state. Organizing itself into a special committee on military preparedness, which subsequently became the advisory committee to the state chairman of Procurement and

Assignment, the Council played a major role in determining which physicians should be declared available for military service and which should be declared essential for civilian medical care.

In 1944, our Association adopted a Ten Point Program and instructed Council to put it into effect. This was no temporary expedient but a long range program which necessitated careful planning and financial support. Acting in its role as financial agent of the Association, Council sponsored voluntary contributions and then an increase in annual dues to care for the situation. A Director of the Program was elected and his work was supervised by the Council.

Here are some of the phases of the Ten Point Program which the Council has sponsored and helped to put into effect during the past seven years—the establishment of the South Carolina Hospital Service (Blue Cross) Plan, the establishment of a State Health Council, the establishment of the South Carolina Medical Service (Blue Shield) Plan, the Medical College Expansion Program, a state wide hospital survey, a Speakers Bureau, the killing of a bill in the Legislature to change the present organization of the governing body of our State Board of Health, the placing of physicians in needed areas of the state, the Centennial Celebration of our Association in 1949, the improvement of our Journal, the printing of an annual directory, the publication of a history of our Association, setting the Association on such a sound financial basis that it was possible to lend the South Carolina Medical Service Plan $10,000.00 with which to set up business, and to give $10,000.00 to the National Medical Education Fund (earmarked for our own Medical College)—all of which came from our current expense account, without the necessity for drawing upon our reserve fund.

Two criticisms have been leveled at the Council during recent months. The number who make these criticisms are not great but their voices have been loud enough to carry some distance.

The first criticism is that the Council is doing too much, that it is usurping its powers. What a far cry this is from the criticism of earlier years when one was told that the Council was doing nothing. To us it is a sign of activity.

As we have read the constitution and the minutes of the House of Delegates, with its resolutions outlining further duties for Council (such as the implementation of the Ten Point Program), we do not believe, in all sincerity, that the Council has overstepped its pregoratives. It may be true that the Council has not kept the members of the Association fully informed as to what has been done—and yet the minutes of all meetings are published in the Journal.

The second criticism is that the Council has been unwise in some of its financial activities leading to unnecessary expense. To those who make this criticism we would ask that they compare the financial condition of the Association today with what it was ten years ago. On Dec. 31, 1940 we had $3,646.48 in our cash account and $1,000.00 in our reserve fund. On Dec. 31, 1950 we had $14,616.34 in our cash account, $15,000.00 in our reserve fund, and a note for $10,000.00 due from the South Carolina Medical Service Plan.

We would further ask these critics to consider the various activities and accomplishments of our Association during the past ten years (particularly during the past seven years since our Ten Point Program has been in effect) and to ask whether they have not been worth a monthly expenditure of only $1.67 per member of the Association, (and this includes the Journal).

Misunderstandings have arisen and it is our sincere hope that this discussion of the Council will help to clarify the atmosphere. That the members of Council have made their mistakes we will readily admit, but we are convinced that they have been mistakes of the head and not of the heart. It has been our privilege to know every member of the Council intimately during the past twelve years and we can say without reservation that they have given of their best to the interests of the Association. Today, as always, they need the advice and constructive criticism of all our members and we hope that this will be given freely. We beg for them the loyal support and confidence of each and every member of our Association.

SUGGESTED OUTLINE AND AGENDA FOR ANNUAL MEETINGS SOUTH CAROLINA MEDICAL ASSOCIATION

Monday

2:30 P. M.—Meeting of Council

Tuesday

9:00 A. M.—Convocation House of Delegates

1. Remarks by President
2. Address by President-Elect
3. Reception of recommendations and resolutions from (a) Council, (b) Secretary, (c) Treasurer
4. Reception of recommendations and resolutions from (a) Chairmen of Standing Committees, (b) Chairmen of Special Committees
   (All reports with their resolutions and recommendations will have been previously printed in *The Journal*. The reports will not be read—but only the resolutions or recommendations. The reports and recommendations will be referred to reference committees previously appointed—without discussion.)
5. New business—Matters of consequence requiring action should be in writing and where practical should have been printed along with other resolutions. These will be referred to reference committees.
6. Announcement of meeting places of reference committees.

12:00 Noon—House of Delegates rises and immediately sits as the Corporation of the South Carolina Medical Care Plan, the President of the Plan presiding.
1:00 P. M.—Adjournment.
3:00 P. M.—Reference committees meet
(Not only delegates, but all members of the association are invited and urged to attend and to participate in those meetings considering matters of particular interest to them.)

Wednesday

9:00 A. M.—Convocation House of Delegates
1. Reports from Reference Committees and action on recommendations.
2. Unfinished business.
3. Selection of meeting place.
4. Election of officers.
5. Presentation of new President-Elect and Vice President.

12:30 P. M.—Adjournment
1:00 P. M.—Alumni luncheon
3:00 P. M.—First Scientific Assembly
5:00 P. M.—Adjournment

Thursday

9:00 A. M.—Second Scientific Assembly
12:30 P. M.—Luncheon Recess
2:00 P. M.—Scientific Assembly reconvenes
5:00 P. M.—Adjournment
7:00 P. M.—President's cocktail party
8:00 P. M.—Banquet
10:00 P. M.—Dancing

(Make the May number of *The Journal* the handbook of the annual meeting with reports, recommendations, resolutions, agenda of the House and program of scientific meetings, biographical sketches of speakers, pictures, etc.—with the printed program—simpler than now.)

SUGGESTED REFERENCE COMMITTEES

1. Committee on Constitution and By-Laws.
2. Committee on Legislation, Public Policy and Public Relations.
3. Committee on Public Health and Medical Practice.
4. Committee on General Management of the Association.
5. Committee on Medical Economics, Fees and Care of Indigent.
6. The Council, sitting as the Finance Committee, to be the reference committee on appropriations, donations, changes in dues and other financial matters, not already under its control.

MINUTES OF COUNCIL MEETING

Monday P. M. May 14, 1951

The Meeting was called to order at the Ocean Forest Hotel, 2:35 p. m., by Dr. O. B. Mayer, Chairman. Those present were Dr. O. B. Mayer, Chairman, Drs. Latimer, L. Smith, H. Smith, Price, Stokes, Chapman, Cain, Tuten, Baker, Guess, Alford, Thackston, Heyward, McCants, Sease, and Mr. Meadors.

The minutes of the previous meeting were read and adopted as read.

The application of the Palmetto Medical, Dental and Pharmaceutical Association of South Carolina, for admission to membership in the S. C. M. A. was presented. After a full and free discussion, it was moved by Dr. Price that Council appoint a Committee, composed of the President of the Association, the Chairman of the Board of Trustees of the Medical College of South Carolina, and the Senior Delegate of the State Association to the American Medical Association. This Committee to arrange a meeting with a similar Committee of three from the Palmetto Medical, Dental, and Pharmaceutical Association, for a full discussion and to report the results back to Council at the next annual meeting. This resolution to be presented to the House of Delegates for consideration.

The status of Dr. C. S. Breedin of Anderson was discussed, since he still wishes admission to the Anderson County Medical Society. This was received as information.

A letter from Dr. Stanley H. Hill, Chairman of the Planning Committee of the Mississippi Medical Association, in regard to the Negro question, with the Secretary's answer, was read and accepted as information.

The matter of Honorary Members was considered. Dr. J. M. Symmes, Dr. C. H. Blake, Dr. W. P. Turner, Sr., Dr. C. E. Crosley, all of Greenwood, were all made Honorary Members on recommendation of their County Medical Society. Dr. C. A. Pinner, Sr., retired, was elected to Honorary Fellowship.

The revision of the Constitution, with the Amendments up to date, was discussed. It was moved by Dr. Guess that Council recommend to the House of Delegates that a special Committee be appointed to revise and print the Constitution. This was passed.

A copy of the resolutions to be presented to the House of Delegates of the A. M. A. by the Ohio State Medical Association, regarding the abolishment of Fellowships, was presented to each of our Delegates to the A. M. A. Each was also given his credential card, properly filled out.

Since N. B. Heyward, Secretary, had been personally publicized in the financial statement of the Association, an itemized statement showing the disposition of each dollar spent, was presented to each member of Council, for information.

It was decided to present to the House of Delegates, the matter of the permanency of the Historical Committee, Dr. J. I. Waring, Chairman.

Dr. Price's motion that the S. C. M. A. donate $2500.00 (later amended to $5000.00) to The National Medical Education Fund was discussed. This was referred to the House of Delegates for endorsement, since Council is responsible for all funds.

Dr. Joe Cain's resolution in protest against hospitals hiring doctors to do the work in the hospital, the hospital collecting the fees, was passed and referred to the House of Delegates for further action.

Dr. Baker's letter, complaining of the Industrial Commissions Fees, was referred to Dr. Frank Owens, Chairman of that Committee.

Dr. Guess moved that Dr. Frank Owens' Committee on Industrial Fees be continued for another year to complete its work.

The report of the Committee on the establishment of a Grievance Committee was presented by Dr. Roderick Macdonald, Chairman. This was approved by Council and Dr. Joe Cain moved that this plan be presented to the House of Delegates by Dr. Macdonald and that Dr. Macdonald be granted the right to furnish a copy to Governor Byrnes, if and when it was adopted by the House of Delegates.

Dr. Guyton reported on Civil Defense activities.

Dr. Wyman King spoke favoring the idea of a Hospital for Alcoholics with a message from the general practitioners. He asked the appointment of a committee, to be appointed by the President, to work with the general practitioners group to promote this plan.

Dr. T. G. Goldsmith spoke briefly and introduced two speakers on the Principles and Objectives of the Association of American Physicians and Surgeons, Inc. He asked the opportunity to present their program to the House of Delegates. He was allowed 30 minutes time, under new business.

Dr. John Rainey of Anderson wrote in protest over several state-wide matters and his letter was received as information.

The report of Dr. William Weston, Jr., Chairman of the Membership Committee, was read with recommendations. The letter was received as information. It was moved by Dr. Stokes that a copy of these recommendations be sent to each County Society.

Dr. Guess reported on his plan for changing the order of business for the House of Delegates. He suggested having two sessions of the House of Delegates. At the first session all reports and motions to be referred to a reference committee. This Committee to consider and have hearings on all referred matter and to make recommendations to the second session of the House of Delegates, for action. Dr. Guess also presented Blue Shield matters and recommended certain members for the Board of Directors and for the establishment of an advisory committee for the fee schedule of the Blue Shield. Council nominated Drs. Stokes, Baker, Goldsmith, Waddy Thompson, Jr., and Mr. Gilhooley.

Dr. Stokes, Treasurer, made his report. This was received as information. Dr. Stokes moved that this Association adopt the rule of the A. M. A. as to the arrears in dues. This was passed.

The report of Dr. Price, Editor of The Journal, was received as information.

It was decided after considerable discussion, to publish a directory of the membership every two years. This was on the motion of Dr. Baker, seconded by Dr. Sease.

It was moved by Dr. Stokes that the letter, with report from Mrs. Hutchinson, Chairman of the Legislation Committee of the Woman's Auxiliary, be turned over to the new Public Relations Committee of the Association, for consideration.

Mr. Meadors outlined his report to the House of Delegates. This was approved.

Council was recessed at 6:45 p.m., until 10:00 a. m. on May 15th, to meet with the officers of the Woman's Auxiliary.

Meeting of May 15th

The Meeting was called to order at 10:05 a. m., May 15th, by Dr. Mayer, Chairman, with a quorum present.

A report was heard from Mrs. A. F. Burnside, retiring President of the Woman's Auxiliary and also a report from Mrs. Kirby Shealy, the incoming President. Mrs. Wilson, Treasurer of the Woman's Auxiliary also reported. The ladies all gave instructive and interesting reports and were thanked by the Chairman for appearing.

A motion was made by Dr. Sease that a Committee be appointed for the release of news to the public and that it be released through Mr. Meadors, Director of Public Relations. It was moved by Dr. H. Smith that this Committee be composed of the Vice-President, the Secretary and the Editor of The Journal.

Mr. Meadors reported on the entertainment for Tuesday evening and it was moved by Dr. H. Smith that $600.00 be allowed for this entertainment. This was passed.

President W. R. Tuten asked Council to endorse the request of the Dental Association that a school of dentistry be established in connection with the Medical School in Charleston. After considerable discussion this was approved, and it was moved by Dr. H. Smith that this recommendation be presented to the House of Delegates for approval.

The Meeting was then recessed to meet at 9:00 a. m. on May 16th.

Meeting of May 16th

The Meeting was called to order May 16th at 9:00 a. m. by Dr. Mayer.

The first order of business was the election of officers. Dr. O. B. Mayer was elected Chairman and Dr. Jeff Chapman, Vice-Chairman. Dr. Price was elected clerk of the Council.

On the motion of Dr. H. Smith, Dr. J. D. Guess was nominated as an alternate delegate to attend

the meeting of the House of Delegates of the A. M. A. in June, since Dr. Smith resigns as delegate as of July 1st, 1951. Dr. William Weston, Jr., was nominated to attend the December meeting of the House of Delegates of the A. M. A. It was moved by Dr. Guess that Dr. Weston be nominated to fill the unexpired term from July 1st, 1951 to January 1st, 1952.

Dr. Julian Price was unanimously re-elected Editor of The Journal. Mr. M. L. Meadors was re-elected Business Manager & Director of Public Relations.

It was moved by Dr. H. Smith that the Treasurer make out a check to the A. M. A. Educational Fund for $10,000 with the specification that this money be earmarked for the Medical College of South Carolina and that it be applied to the purpose of increasing the capacity of the student body. Dr. Price moved that a telegram be sent to the A. M. A. Educational Foundation that the House of Delegates of the South Carolina Medical Association had appropriated $10,000 to its fund, under the conditions just outlined.

The Committee was appointed to serve with the Committee from the Palmetto Medical, Dental and Pharmaceutical Association, to be composed of the President, the Chairman of the Board of Trustees of the Medical College, and the Senior Delegate to the A. M. A. The President to have the authority to appoint a substitute for any vacancy on the Committee.

It was moved that next year's Annual Meeting be held the week of May 11th, since the North Carolina Medical Assn. meets the week of May 4th.

Mr. Meadors was instructed to protest with the Management against the increase in price for the food furnished at luncheons and banquets. The same food furnished for $1.50 for regular luncheon guests was raised to $3.50 for the scheduled Association luncheons.

The Meeting was then recessed until 8:45 a. m. on May 17th for the purpose of receiving estimates of the budgets of the various officers.

Meeting of May 17th

The Meeting was called to order at 8:45 a. m. by Dr. Mayer, Chairman, on May 17th, with a quorum present.

It was moved by Dr. Chapman that budget estimates be postponed until a meeting called at the discretion of the Chairman, since the Treasurer and the Editor of The Journal were not present.

It was moved by Dr. Wyatt (Dr. H. Smith) that the various officers have their budgets ready to present to the Annual Meeting each year.

It was moved that a Committee be appointed to protest the charges of the dining room, for big meetings. This Committee to be composed of the President, Business Manager, and the Secretary.

Adjournment at 9:50 a. m. to meet again at the call of the Chairman.

Respectfully submitted,
N. B. Heyward, M. D.
Secretary

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

PRESIDENTIAL INAUGURAL ADDRESS

by

John W. Cline, M. D.
President, American Medical Association

Doctor Bauer, Doctor Henderson, Mr. Speaker, Members of the American Medical Association, and Fellow Americans:

The American Medical Association was founded one hundred and four years ago—to improve medical education and elevate the standards of medical care. Throughout its history these have remained its major objectives.

Except for a few war years, the Association has held an annual session and the 100th meeting is now taking place in Atlantic City. The medical welfare of the people of our country is entrusted largely to the medical profession. Current health conditions and medical progress will be reported at this meeting—and by the way of the press, radio and other media, will be transmitted to the Nation.

It is a great privilege to address my colleagues here assembled, and to speak to the physicians throughout the country and to the American people, concerning the American Medical Association, its aims and objectives.

THE WORLD LOOKS TO AMERICA FOR LEADERSHIP. As history counts the years, the United States is a youthful country and American medicine also is young. Our country and the medical profession and the medical institutions which serve it have reached early maturity. Today, as never before, the World looks to us for guidance and leadership.

We are the most favored among Nations because the light of liberty burns brightly here. Individual freedom, opportunity and incentive are the cherished birthright of our people. Likewise, we of American medicine are most favored among doctors. We live and work in an atmosphere of individual liberty, and we have the priceless stimulus of academic and scientific freedom. We are strong because we possess the dignity of free men.

ONLY FREE MEN CAN PRESERVE OUR MEDICAL ACHIEVEMENTS. Only if we perpetuate this heritage can we continue to provide the ever improving quality of medical care which is the right of the American people.

During the past two and one-half years we have been compelled to fight to maintain this essential freedom. The critical struggle to remain a free profession was not of our asking, but was forced upon us by those who have lost faith in traditional American concepts, and by those who hold the welfare of the American people to be less important than their own political advantage.

We undertook to acquaint the people with the facts. They have recognized this hazard to the quality of their medical care and the danger to their freedom inherent in Socialized Medicine. They have spoken out clearly and emphatically against it. We are grateful for the perception and the unequivocal expression of the American people.

SERVICE TO HUMANITY IS MEDICINE'S PRIME OBJECTIVE. The "Principles of Ethics of the American Medical Association" opens with this statement: "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

To every doctor of medicine, let me say that this is a time for searching self-examination and earnest rededication to the high principles of our profession. We hold in trust the medical welfare of the Nation—and to that trust we owe, not only the conscientious application of our skills, but tireless devotion.

To me, this hour marks the high point of my career. It is the beginning of a year of service to the health and medical welfare of our country and to my profession.

It is a great honor to become President of the American Medical Association, but I assume that office without false pride. The responsibility, not only to American medicine, but to the American people is great. I accept it with humility—born of its importance, but face the coming year with confidence based upon an intimate knowledge of my profession, and a steadfast belief in its ability and determination to render progressively greater service to our people.

THE THREAT OF CATASTROPHE—ON TWO FRONTS. These are troubled times. The dark clouds of war hang menacingly over us. We must be prepared for catastrophe, should it come. If it does, the responsibilities of medicine will increase many fold. The Association has been working closely with the Department of Defense and other agencies of Government in planning for such eventuality.

Simultaneously, we face the possible loss of freedom through the destruction of our constitutional guarantees of liberty and through avarice or moral disintegration in high places. As citizens, regardless of our occupations, we must recognize that the right of self-determination— the right to be master of one's own destiny—has disappeared in many countries. It is threatened in others, including our own.

The independence of the individual, his freedom of speech and his right to follow the trade or profession of his choice are basic issues. Only those who now enjoy such advantages can preserve them.

THE AMERICAN PEOPLE WILL RESPOND. I have a deep and abiding faith in the intelligence and integrity of the American people. They will respond as they did when their medical welfare and their medical freedom were threatened.

We accepted the challenge of the would-be Socializers not only because of the threat to our own professional freedom, but on behalf of the welfare and freedom that is the right of all Americans. The members of the American Medical Association are more vigilantly alert than ever to their duties as citizens and will oppose Socialistic schemes which would jeopardize the freedom of any segment of our society.

Primarily, we are physicians and our first obligation is to protect and preserve the health and medical welfare of the American people. A number of factors influence these important aspects of life, but medical care is one of the foremost. It is, therefore, appropriate at this time, for American medicine to render a report of its stewardship.

AMERICAN MEDICINE ASSUMES WORLD LEADERSHIP. American medicine has gone steadily forward. Some of the once great medical systems of the Old World have faltered and declined under stultifying Government control while American medicine has forged into a position of World leadership.

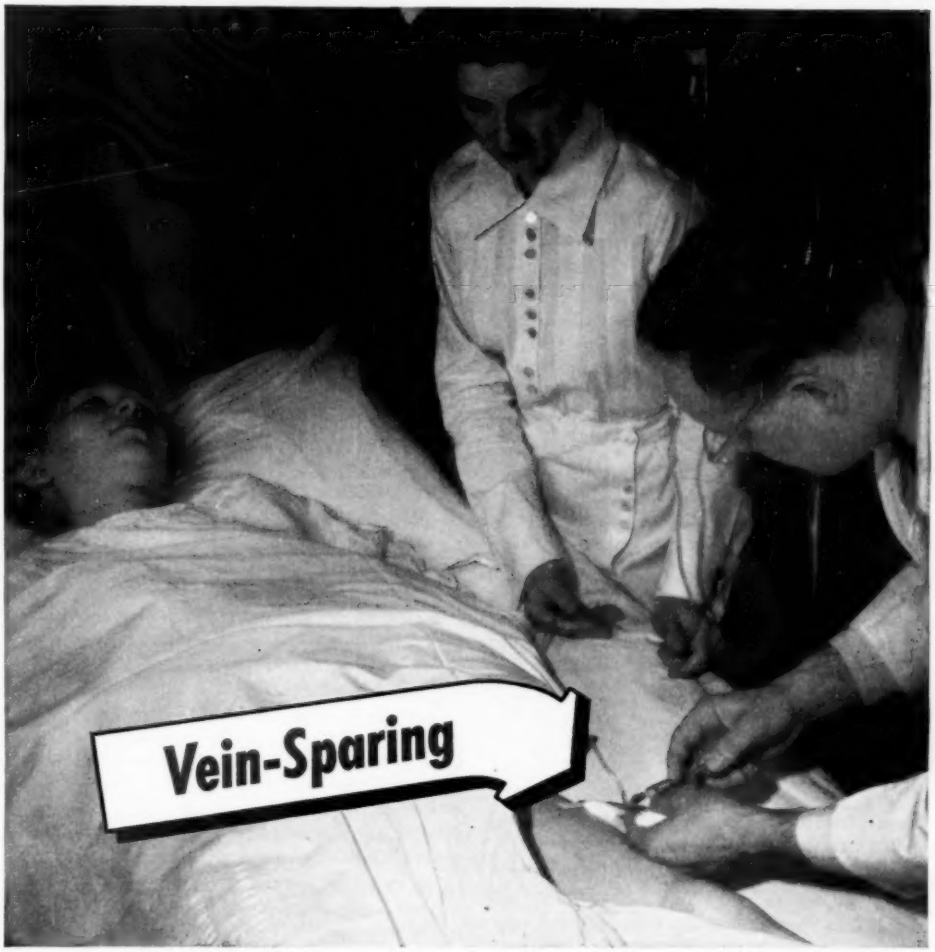
The greatness of any Nation can be measured, in part, by the health of its people. The United States is great and has developed the foremost medical care in the World. You are all beneficiaries, but you are contributors to this system as well.

American medicine could not have attained its present position without the assistance and cooperation of our educational institutions, our scientists, our colleagues in public health, our hospitals, nurses, dentists, labor and management, and all the American people—working with initiative and independence toward the same goal. Together we have made great progress in the fight against death and disease, until today we are the healthiest large Nation in the World.

TWENTY ADDED YEARS OF LIFE. Since the turn of the century, almost twenty years have been added to the life span of the American people. The general death rate during the same period has been cut almost in half. This represents the saving of more than one million American lives every year.

Our population has doubled since 1900, but the population, sixty-five years of age and older—has quadrupled. This results from saving the lives of infants, children and young adults.

An American mother now has better than 999 chances out of 1000 to come through childbirth safely.



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During surgery, Alidase-facilitated hypodermoclysis often offers the distinct advantage of permitting injection at a site remote from the surgical field and eliminates the cumbersome arm board. G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

This is the best record in our history and, on a comparable basis, the best in the World.

In the ten years between 1940 and 1950, infant mortality was cut 38 per cent. At the present rate of progress the record of the United States should be shortly, if not already, the best in the World.

A baby born today has more than 20 per cent greater chance of reaching maturity and almost 45 per cent greater chance of achieving the age of fifty than had a baby born in 1900. At the same time, he faces only about half the hazard of becoming an orphan before reaching maturity.

THE CHOICE IS ACHIEVEMENT VERSUS SOCIALISTIC EXPERIMENT. I believe the mothers of America will consider that these achievements far outweigh the empty promises of those who urge a system of Government—controlled medical care. We cannot afford to sacrifice this record upon the altar of Socialistic experiment.

A recent survey conducted by the World Medical Association among the professions of forty countries, disclosed that the United States was the country preferred for postgraduate study and specialty training.

This country has the finest medical schools, the most modern and efficient hospitals, the best trained and most competent medical profession and by far the highest standard of medical care the World has ever known.

I should like to underscore the next statement. The American people are entitled to this assurance: *No health crisis or medical emergency exists in this country.*

We are proud of the part the American Medical Association has played in this record of progress.

A.M.A. GROWS AS A GREAT PUBLIC SERVICE ORGANIZATION. As our country has grown and changed from a rural to a mixed industrial and agricultural economy, the problems of medical care have multiplied. The American Medical Association has grown and developed correspondingly during the same period.

Few Americans know of the extensive activities of the Association devoted to their welfare. Few realize the degree to which it is a great public service organization. The nine-story headquarters building in Chicago houses more than eight hundred employees, working full time on projects which are directly or indirectly in the public interest.

Early in the present century, medical education in this country was in a deplorable condition. "Diploma mills" and second and third rate schools flourished. The American Medical Association, in cooperation with others, established sound educational standards and began regular inspection of medical schools. Today, all the medical schools in this country are of high quality and are turning out splendid physicians. This is one of the main reasons why medical science has progressed so rapidly in the United States during the past thirty years.

A MEDICAL F.B.I. PROTECTS THE PEOPLE. For the past fifty years, the Association has worked for high standards in the manufacture of drugs and appliances. The American Medical Association itself tests hundreds of drugs and appliances every year. Its seal of approval upon such products assures the profession and the laity, alike, of high quality.

The Association operates what might be described as a medical F.B.I.—which investigates and exposes quack doctors and fake remedies. Every year many worthless medicines and treatments appear upon the scene. The American Medical Association cooperates with law enforcing agencies throughout the country in securing withdrawal of such remedies and in exposing quack practitioners.

A.M.A. FUNDS FOR MEDICAL RESEARCH AND EDUCATION. On the other hand, the Association consistently encourages and assists worthwhile research. Every year the Association spends several hundred thousand dollars to aid research. It was a pioneer in health education, and spends additional hundreds of thousands of dollars annually giving factual health information to the American people through newspapers, pamphlets, radio, television and motion pictures.

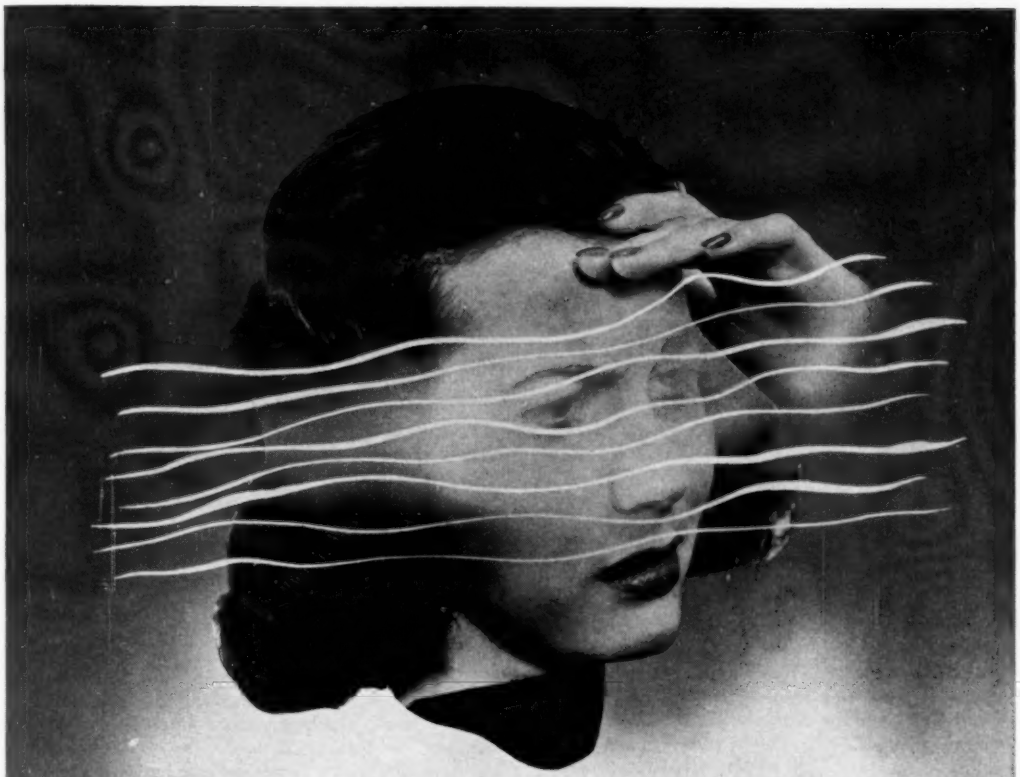
The American Medical Association has promoted the development of sound Voluntary Health Insurance to ease the financial burden of serious illness. As a result of this effort—in conjunction with hospital groups, insurance companies, labor, industry and others—there has been tremendous growth of this type of coverage. Today, more than seventy-two million people have some type of Voluntary protection against the financial shock of illness.

We shall continue our efforts to expand and improve prepaid medical care, and confidently look forward to the enrollment of the vast majority of our people in Voluntary plans within the next few years.

PRIVATE ENTERPRISE IS SOLVING THE ECONOMIC PROBLEM OF ILLNESS. I can make this flat declaration: The problem of insurance against the economic hazards of illness is well on its way to orderly solution within the existing framework of private enterprise.

One of the most important tasks of the Association is to keep its members informed of the latest developments in medical science. To this end, it holds two large meetings each year. The physicians learn by hearing papers presented by leaders of the profession, viewing films and television portrayals of surgical and diagnostic procedures and by wandering through miles of medical exhibits. One physician recently described such a meeting as "a complete postgraduate education under one roof."

To inform the physician who cannot attend these meetings and to eliminate delay in presenting new discoveries made between meetings, the Association



hay fever...

Neo-Synephrine acts quickly to relieve the distress of hay fever, shrinks the engorged mucous membranes, checks hypersecretion, permits free breathing and promotes comfort.

It is notable for

- excellent tolerance
- relative freedom from compensatory congestion
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Its effectiveness is undiminished by repeated use—insuring topical relief throughout the hay fever season.

NASAL USE	OPHTHALMIC USE
¼% solution (plain and aromatic), 1 oz. bottles; 1% solution, 1 oz. bottles; ½% water soluble jelly, ⅝ oz. tubes.	⅛% low surface tension, aqueous solution, isotonic with tears, ½ oz. bottles.

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Prompt and Prolonged HAY FEVER RELIEF

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BRAND OF PHENYLEPHRINE

regularly publishes ten scientific journals and several books. The weekly Journal of the American Medical Association is the most widely read and most highly esteemed of all medical periodicals.

What do these activities mean to you, the public? These services of the American Medical Association keep your doctor up to date through his years of practice so that he may render the best medical care to you and to your family.

A.M.A. WORKS IN ALL FIELDS OF HEALTH. The Association is concerned with the health problems of all segments of society. It studies industrial hazards, cooperates with labor and management to eliminate them, and holds an annual conference on industrial health.

It does similar work in the field of rural health, where it works with those organizations interested in rural problems. It has helped design plans for placing doctors in rural areas where they were needed.

The Association is currently studying means of improving services for those in the lower income brackets. It is one of the co-sponsors of the Commission on Chronic Illness which studies diseases of long duration, particularly those of the aged.

One Council is devoted entirely to the problems of Civil Defense and the Armed Forces. Another Bureau compiles and analyzes medical statistics. It recently completed the only National study of blood banks which has ever been made. The Nation is now in a position to know the requirements for blood and the sources of supply.

AVAILABILITY OF GOOD MEDICAL CARE CONSTANTLY INCREASING. In medical problems that are best solved at the local level, the Association serves in a coordinating and advisory capacity to State and County Societies. It urges programs such as that to make medical care available at any hour by the establishment of night and emergency call systems in all communities.

Another project is the Nationwide development of grievance committees—to hear and act upon complaints which patients may have concerning any aspect of medical service. Thirty-six States now have such committees.

There are many other public service projects of the American Medical Association, but this brief discussion perhaps will demonstrate the substantial contribution which organized medicine has made and is making to America's health.

Problems still exist and no one is more aware of them than the medical profession. Certain rural areas and some Government services need more physicians, but there is no real shortage of physicians.

The United States has more doctors than any country and except for Israel, where an abnormal situation exists, a higher ratio to the population than any Nation.

COOPERATION SOLVING PROBLEM OF DOCTOR DISTRIBUTION. Medical care is less available in certain areas than in others. However, the American Medical Association and the State and County Societies are assisting such communities to obtain more doctors; they endeavor to bring together the doctors seeking places to practice and the localities in need of physicians.

The problem is one of distribution rather than shortage. Significant improvement has taken place and is continuing, as a result of the cooperation of the branches of medical organization with the local communities in need.

Looking toward the future, the American Medical Association favors training more physicians. Our medical schools have expanded their enrollments. At this time, there are more students preparing for careers in medicine that at any time in our history, and by 1960 we will be producing at least 30 per cent more physicians than we did in 1950. This tremendous growth will be accomplished without sacrifice in the quality of education. To fail to maintain our present high standards would be ruinous to the future of medical care.

A.M.A. STIMULATES PRIVATE SUPPORT FOR MEDICAL SCHOOLS. Some of our medical schools, however, are in financial distress. This is a matter of deep concern to the American Medical Association. In appreciation of this situation, the Association has donated a half million dollars in an effort to stimulate realistic private support for medical education. Other Societies have contributed lesser amounts. On May 16th last, the Foundation created by the Association was merged with the National Fund for Medical Education headed by Mr. Herbert Hoover. I urge every physician to contribute promptly and generously.

In addition, we advocate one-time Federal grants for necessary remodeling and construction. The Association believes that medical education can be financed adequately by these means and without danger of Federal control.

We recognize the great service to medical advancement rendered by our full-time basic science and clinical teachers, and seek to improve their opportunities.

AMERICAN MEDICINE DEDICATED TO HIGH PURPOSES. In a changing World nothing is static and new problems will arise. Physicians do not issue careless statements concerning the health of an individual or a Nation. I make no irresponsible, utopian promises, but I assure you that we are attacking the problems confronting us with the same determination that has characterized our battle against disease.

I am proud to serve as President of the American Medical Association. It is a truly American institution, democratic in organization and dedicated to high purposes. It has one hunderd forty-odd thousand members—the vast majority of American physicians engaged in the care of the sick.

The greatness of American medicine is inseparable from the over-all greatness of America. It has sprung

new DURABILITY new CLEANLINESS
new COMPACTNESS new BEAUTY

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INSTRUMENT CASE

This compact case is made of reinforced material to withstand far more stress and wear than any case will receive in normal use. It has amazing resistance to scratches and abrasion, and retains its like-new appearance for years.

The soft rubber lining protects the instrument against shock damage. Like the entire case, it can be washed with soap and water and sterilized by wiping with alcohol, an impossibility with old style plush-lined cases.

The "Sandura" case takes up less room in your bag and slips easily into your coat pocket.

All Welch Allyn otoscope sets or otoscope-ophthalmoscope sets with large handles are now available in this new "Sandura" case. Cases may also be purchased separately.

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ORIN R. YOST, M. D. PSYCHIATRIST-IN-CHIEF

TELEPHONE 1620

from the same freedom which has made possible the attainment of high standards in all fields of endeavor.

PHYSICIANS, AS CITIZENS, PLEDGE FIGHT FOR AMERICAN FREEDOMS. Democracy and democratic institutions are on trial. It is an historical fact that men must control themselves and their destinies or be controlled by others. The philosophy of statism is foreign to the American concept of life.

American medicine eagerly assumes its responsibility to provide medical care of ever higher standard for the American people and to bring that care progressively within easier reach of those who require it. At the same time, the physicians of this country pledge themselves to dynamic activity as citizens to preserve the freedom which is requisite to the fulfillment of their medical obligations to the American people.

EMERGENCY MEDICAL CALLS*

One of the responsibilities of the county medical society today is providing emergency service to the residents of any community. The inability of any individual to secure a physician in emergency cases, has been the basis for one of the most serious accusations against the profession as a whole.

Night calls, emergency calls, have been thoroughly discussed in medical journals, county society bulletins, and in THE LAY PRESS. The Council on Medical Service of the American Medical Association conducted a survey during the summer of 1948 and found that only about 60 county medical societies had developed any formal plan for handling emergency and night calls. The increasing pressure on this phase of medicine has resulted in bringing this total to 100 or 120.

The problem varies according to the population of any community. Plans adaptable in a city of 100,000 would not be necessary in a town of 5,000. However, the plan which would be successful in a city of 100,000, might not be the answer in a metropolitan area.

Illinois presents a complicated picture of metropolitan problems and rural situations to make it necessary that the plan adopted fit the community which it serves. For this reason, the solution rests upon the county medical society.

The Council on Medical Service of the American Medical Association has developed a pamphlet which outlines 16 plans representing a cross-section of the various approaches being used throughout the country by medical societies.

James R. McVay, M.D., Chairman of the Council, writes: "Every county or city has real emergency cases, and one of the weak spots in many medical care programs is the inability to put physicians in immediate contact with such cases. The first requisite to successful handling of emergencies is an understanding and cooperative medical profession. Some physician has to make the emergency night call; every physician should do his part so that the burden does not fall on the FEW. The second requisite is a well defined plan for handling such calls—a plan which is understood and accepted by the public and the physicians. It is hoped that this pamphlet will be of assistance to many societies in devising a workable plan."

Write to the Council on Medical Service
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

and request that they send you: "Planning for Emergency Medical Calls"—A Resumé of the plans of 16 county medical societies.

If your society has not been active in this phase of medical care planning, now is the time for you to add this to your list of important services to be provided for the residents of your community.

IT'S GOOD PUBLIC RELATIONS.

*Reprinted from the Illinois Medical Journal, May 1951.

MODERATE RISE IN MORTALITY

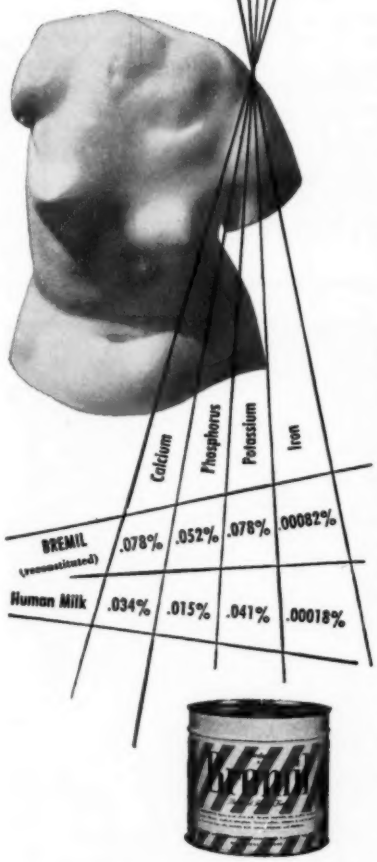
In the first quarter of 1951 the death rate among the Industrial policyholders of the Metropolitan Life Insurance Company was 7.1 per 1,000, or 3.3 percent above that for the like part of last year. Two factors account for the major part of this increase: the widespread outbreak of respiratory disease and, to a lesser extent, the loss of life due to the Korean War.

The war losses show up clearly in the record for white males at the main military ages. Thus, in the age group 15-19 the general mortality rate was 68 percent higher than the rate a year ago; at ages 20-24 the rise was 56 percent. Relatively small increases in the death rate were also recorded among men at ages 45 and over; at some of the younger ages, however, there were moderate declines. The net result of these changes has been to bring the death rate for white males 5 percent above that for the first quarter of 1950. Among white females the death rate has decreased at every age group except the preschool years.

The outbreak of respiratory disease is reflected in the increased death rate from pneumonia and influenza. For the January-March period, the pneumonia mortality among the Industrial policyholders was 22.0 per 100,000, compared with 19.2 a year ago; for influenza the corresponding figures are 4.6 and 2.7 per 100,000. There were fears at the beginning of the year that the epidemic, which affected large areas of the world, might prove to be catastrophic in character. These fears are now allayed by the subsidence of the outbreak.

The major diseases of middle and later life likewise registered a rise in mortality so far this year as com-

a **new** *product*



conforming to the pattern of human milk...

BREMIL—newest product of Borden research—a significant advance in infant nutrition.

BREMIL is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk.

In **BREMIL** the calcium-phosphorus ratio is adjusted to a guaranteed minimum of 1½ parts calcium to 1 part phosphorus. Gardner, Butler, et al., state: "Relative to human milk, cow's milk has a low Ca:P ratio..."[1] Nesbit states: "Tetany of the newborn is now recognized as a definite entity... and often accompanied by an increased phosphorus and lowered blood calcium."[2]

BREMIL is fortified with ascorbic acid as inadequate vitamin C often leads not only to scurvy but also to megaloblastic anemia.[3]

BREMIL has the fatty acid pattern of human milk.

BREMIL has the amino acid pattern of human milk.

BREMIL is easily digested as it forms a soft flocculent curd of small particle size comparable to human milk.

BREMIL supplies the same carbohydrate as human milk.

In **BREMIL** vitamins A and D, thiamine, riboflavin, niacin, and ascorbic acid have been *standardized at or above* the recommended daily allowances.[4]

BREMIL is available in drugstores in 1 lb. cans.

Complete information and a trial supply may be obtained upon request.

1. Gardner, L. I.; MacLachlan, E. A.; Pick, W.; Terry, M. L., and Butler, A. M.: *Pediatrics* 5:228, 1950.
2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.
3. May, C. D., et al.: *Bull. Univ. Minnesota Hospitals* 21:208, 1950.
4. Recommended Daily Dietary Allowances, Rev. 1948, Food & Nutrition Board, National Research Council.

flexible, palatable, easy to prepare

Bremil®

powdered infant food

Prescription Products Division

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pared with last. The death rate from the malignant neoplasms, and from the cardiovascular-renal diseases increased a little more than 2 percent; the rise for diabetes was considerably greater. Part of the increased mortality from the chronic conditions probably resulted from the high prevalence of the respiratory diseases.

Tuberculosis, however, continues its marked downward trend. The death rate from this cause is one fifth below the previous minimum recorded in the first quarter of 1950. Among these policyholders the rate is now down to 18.1 per 100,000—a remarkably low level. Even more spectacular is the experience for the principal communicable diseases of childhood; the death rate from measles, scarlet fever, whooping cough and diphtheria together is now only 0.5 per 100,000. New low rates are also in evidence for the complications of pregnancy and childbirth, for appendicitis and for gastritis. Acute poliomyelitis shows the same rate as in the first quarter of last year—0.3 per 100,000.

Fatal accidents are somewhat higher this year than in 1950, although the death rate from motor vehicle mishaps recorded a slight decline. The increase reflects in part the rise in occupational fatalities, following the marked upswing in the number of persons employed in heavy industry and in the defense effort generally. Suicide and homicide both show a small decline.

HISTORICAL SIDELIGHTS

WILLIAM HENRY JOHNSON, M. D.

AUSTIN T. MOORE, M. D.

Columbia, S. C.

The subject of this paper is perhaps the outstanding unforgettable character of my life. He was a man whom at first I feared and later learned to love.

Doctor William Henry Johnson was in charge of the Department of Orthopedic Surgery during my student days at the Medical College of the State of South Carolina in Charleston and at the time of my graduation in 1924. It was during that time that I, along with other students, feared him. Later I came to recognize his strength of body, mind and character, and I learned to love him when I was honored by an appointment to the faculty of the Medical College as lecturer in orthopedic surgery. This took place in 1929 and after I had returned to Columbia to practice orthopedic surgery following the completion of my post graduate work in Philadelphia.

It was my privilege to make weekly trips to Charleston for the next few years and to come to know Doctor Johnson more or less intimately. I was allowed to organize an out-patient orthopedic clinic, to lecture to the junior and senior classes, to have ward and private patients and to conduct an orthopedic clinic for the students. My days were full ones. It was necessary for me to leave Columbia at 5:00 o'clock in the morning. Usually it was well past midnight when I returned. I remember on one visit there were ten operative cases awaiting my attention.

As I look back on it now, how Doctor Johnson could have been so gracious, so cooperative and so kind to me, an inexperienced and aggressive youngster, is amazing. Particularly is this true when it must be remembered, as will be brought out later, that he was not an operative surgeon, but he was kind and good to me and tolerant of me. I loved him and respected

him and our relations were most cordial. In 1931 it was necessary for me to discontinue my work in Charleston and I was succeeded by Doctor F. A. Hoshall, the present head of the orthopedic department. Doctor Johnson's tolerance of me, his warm and guiding friendship and his complete co-operativeness in helping me during the days I was teaching at the Medical College is, to my mind, one of the finest examples of magnanimity.

YOU, Doctor, are the best judge, so

BELIEVE IN YOURSELF!

With so many claims made in cigarette advertising, most doctors prefer to judge for themselves. So, Doctor, won't you make this simple test?

Take a PHILIP MORRIS— and *any* other cigarette. Then,

1. Light up either one. Take a puff—don't inhale—and s-l-o-w-l-y let the smoke come through your nose.
2. Now do exactly the same thing with the other cigarette.

Then, Doctor...BELIEVE IN YOURSELF!

PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.
100 Park Avenue, New York 17, N. Y.

Doctor Johnson died in 1934. As the years passed, I began to think more and more of writing a memorial to his life to present to our Medical Club here in Columbia. When my turn came to read a paper in 1943, I had determined to make this my subject. I visited with Mrs. Johnson, who was very interested in the project. She talked with me freely about many phases of her husband's life and she gave me a great deal of historical data about him and the family. We reviewed his scrapbook and a few manuscripts. She gave me a few personal papers, one or two newspaper clippings and a copy of the memorial resolution that had been presented to the Medical Society of South Carolina in Charleston. Other than this there was no testimonial evidence to which I could refer. It was surprising that there was so little of record concerning the life of this interesting man.

During my association with Doctor Johnson, he had revealed himself to me in many ways, but I hesitated to use this alone as my source for material. I realized that only by interviewing his associates and those who knew him best could a reasonably full and accurate accounting be obtained. Such an undertaking would be most difficult for anyone not living in Charleston, yet the idea was most fascinating because one only needed to mention the name of Doctor Johnson to anyone who knew him to immediately provoke an enthusiastic recitation or anecdote concerning him or some unusual phase of his life. For various reasons, my decision to write a paper at that time was postponed.

On November 7, 1946, Doctor John A. Siegling of Charleston presented a delightfully written memoir of the life of Doctor Johnson to the Medical History Club of that city. This splendid paper was published in the Journal of the South Carolina Medical Association in April 1947. With Doctor Siegling's permission, his paper will be drawn on freely in the preparation of my presentation.

William Henry Johnson, scion of distinguished lineage, was born in Charleston, South Carolina, on March 30, 1879. His parents were William Johnson and Mary Holmes Mellichamp Johnson. His boyhood days were spent in Charleston where he attended private schools. In 1888, at the age of eighteen, he entered the University of South Carolina and completed a three year course in science in 1891. The following two years were spent at The Medical School of the University of Virginia where he graduated in 1893. Evidently the medical curriculum of that day consisted of a course of only two years. Due to his inheritance, Doctor Johnson found himself at the time of his graduation a man of substance and independent means.

There were no prolonged periods of prescribed post graduate training in those days and the opportunity for study in this country was somewhat limited. Europe was the mecca of medical knowledge. Having financial security and the means at his disposal to satisfy his burning thirst for further knowledge, it is interesting to learn that Doctor Johnson embarked on a course that consumed the following seven years of his life pursuing post graduate studies in America and abroad, in the profession he had elected to follow.

No doubt he realized the brevity of his formal medical education in 1893 and he was resolved to be fully prepared for his private practice which did not begin until the year 1900. This resolve was the source of great gratification and pride to his father-in-law, the late Bishop Ellison Capers, who used to take pleasure in stating that he knew of no other person who had a roll of diplomas as large as his leg.

During the seven years following his graduation, Doctor Johnson spent considerable time in New York City, studying a variety of subjects. He studied the treatment of fractures with Royall Whitman, pediatrics with Seibert and Holt, and gynecology and obstetrics at the Lying-in-Hospital. He habituated the Carnegie Laboratory, the Mothers and Babies Hospital and the House of Relief connected with the New York Hospital. Furthermore, he followed a special course of study at the Bellevue Hospital Medical College.

Leaving New York he spent two years visiting famous medical clinics in Europe, principally studying dermatology in the Clinics of Berlin and then he sojourned for about a year in Russia, where he became deeply interested in the study of leprosy. The latter effort cannot be written off as pure academic knowledge, for it is recorded that he did actually encounter and treat a single case of leprosy later after he had become engaged in private practice in Charleston.

In 1898 Doctor Johnson had the great good fortune to win the hand of the lovely Miss Lottie Capers who was to be so patient, loyal and devoted to him the remainder of his life. Following their marriage in Charleston, they set off on a four month wedding trip to Europe. Mrs. Johnson tells a delightful story of how her husband who had already traveled so much abroad was anxious to impress her with his ability as a linguist in each of the countries that they visited. Privately, she was convinced that her gesticulations and pantomine were largely responsible for the success of his efforts.

To this union there were four children; two boys and two girls, who were later to distinguish themselves in their separate walks of life and before Doctor Johnson's death he was to know the pleasure of having eleven fine grandchildren.

It was in 1900 that Doctor Johnson finally ceased his travels and pilgrimages to various places and he finally settled down to the practice of medicine in Charleston. Soon thereafter another change was necessary as Mrs. Johnson became seriously ill and for the benefit of invigorating mountain air, they removed to Sewanee, Tennessee. There, Doctor Johnson not content with being idle, joined the faculty of the Univer-

sity of the South and taught anatomy and pediatrics and dermatology.

Soon Mrs. Johnson's health was restored and they returned to Charleston in 1901 where Doctor Johnson resumed his practice. His residence was established at 107 Wentworth Street and there he also had his office and laboratory that was to become a unique institution of its own.

On resuming his private practice he also took on the responsibilities of City Physician and attending patients in jail. In recognition of his special training he was requested to teach gynecology at the Polyclinic and roentgenology at the Medical College.

He entered into his work with such assiduity and enthusiasm that soon he was literally buried in his own efforts and was more wedded to his work than his family. His family increased by the advent of four children; two sons and two daughters. These grew up in the house, office and laboratory on Wentworth Street, but Mrs. Johnson told me that Doctor Johnson became too busy to be spoken to and that he did not know his own family.

He became deeply interested in electricity and was the first man in the State to own an x-ray machine. He had various static machines and mechanical devices that he used for treatments. As developments in these machines evolved, his became outmoded and he acquired new ones so that soon he had a vast array of all types of physical therapeutic equipment.

Although it is true that Doctor Johnson was so studious and so deeply engrossed in his work that he allowed little time for family life, certainly it is equally true that he was intensely devoted to each member of his family and, in addition, he was a very devout Christian. He was a member of the Grace Episcopal Church located just across the street from his residence and served on its Vestry for twenty-five years. In times of stress or prior to particularly serious operations he would frequently go over to the church to pray. He was interested in the church history and, at the request of Bishop Thomas, he made notes to conclude the history of Dalcho. Apparently this was never completed. He also did some research work for Bishop Guerry on the history of communion plate in lower South Carolina.

As his office became cluttered with machines, microscopes and paraphernalia of all sorts, his family was called on more and more for assistance. Mrs. Johnson told me that on so many occasions she assumed the role of office nurse. Often some member of the family was used to demonstrate the harmlessness of the whirring sparks from the static machines before a patient could be induced to subject himself to treatment or examination. His young son, Reid, was frequently used for this purpose. Once when answering an inquiry about the static machines Reid stated, "That's what my father uses to kill his patients with." I, myself, remember my first visit to Doctor Johnson's office in my student days. How awesome it was to see the display and hear the crackle of great electrical sparks to the tune of the whir of the motor as a giant static machine was revolved by hand. One of these machines is still preserved in the Charleston museum.

Doctor Johnson's interests were catholic. In addition to private practice he taught successively anatomy, pediatrics, obstetrics, gynecology, dermatology, radiology and, finally, orthopedic surgery. Such a wide sphere of activity is amazing but it must be remembered that Doctor Johnson's mind was such that once his interest was aroused there was no let up in the zeal of his pursuit of the subject until it was mastered to his satisfaction. He perceived an answer to a problem and proceeded to solve it.

While working as city physician, his sense of obligation was such that he felt that it was his duty to make sure of answering promptly every call. For this reason he rigged over the head of his bed a very large bell that was connected by wires to the office door bell. So successful was this apparatus that it not only succeeded in arousing the doctor but everyone else in the household as well.

If he needed a splint he made one. Sometimes it was the leg of a chair, the curve of which suited his fancy. That the chair was an heirloom made no difference. On one occasion he bored a large hole through a beautiful mahogany table in order to pass through some electric wires and mount a lathe so as to facilitate his work.

Mrs. Johnson told me that on another occasion he gave to a needy colored patient some of her beautiful hand embroidered sheets. He gave a $100.00 magnifying glass to a wealthy patient (Mrs. Frost on the Battery) to relieve some skin affection of her face and then advised her to go to see a Doctor Robinson in New York. He used a bag made of fine hand tooled leather to make a splint to treat the son of Doctor Van de Erve when he broke his leg. In addition to his professional service, he frequently gave money to indigent patients. There were many examples of this type of unselfishness and consideration of others.

Another problem of Doctor Johnson's was solved in a very practical way. There was a colored physician, William Henry Johnson from the north, living in Charleston and listed identically in the telephone directory. Naturally, at times there was considerable confusion and annoyance in the telephone calls. Doctor Johnson complained to the telephone company and requested that the word "colored" be placed after the other doctor's name. The company refused this request on the ground that they could not add anything after anyone's name unless at the specific request of that particular party. Doctor Johnson promptly requested that the word "white" be added to his name and so he was listed for the remainder of his life.

He was not a business man. Mrs. Johnson said that he needed a business manager as he kept no records

and made no charges. He inherited a fortune but he spent a fortune in incubators, induction machines and impractical inventions.

For hobbies, he interested himself in photography, the history of Charleston and the Low Country, genealogy and in art. He compiled a large scrapbook on Charleston that included illustrations from Huger Smith's "Dwelling Houses of Charleston." Many other illustrations from other source books were added and, in addition, there were many photographs of his own. These were carefully arranged in symmetrical form, clippings from the texts were included and concise annotations to the whole were painstakingly made in his own hand. He also prepared a manuscript on "A Partial Genealogy of the Family of William Johnson."

His skill as an artist is exemplified in a number of different ways. There still exist several pencil drawings that he made of various members of his family. These are remarkable and almost photographic in character. Doctor James Fouche and others of his earlier students have told me of the anatomical drawings that he made to illustrate his lectures. These were outstanding and correct in minute detail.

With all of his versatility and breadth of experience and knowledge one may wonder how it was that Doctor Johnson finally decided to settle down to the practice and teaching of orthopedic surgery. Perhaps it was his love of things of a mechanical nature, perhaps it was his early training under Whitman in New York. At any event when the Medical College was taken over by the State of South Carolina in 1913 Doctor Robert Wilson, the Dean, approached him and told him of the need of a department of orthopedics in the curriculum. Doctor Johnson replied that he would brush up on the subject a little and that he would be that department. Aside from a nineteen months period of military service he remained head of the department until his death.

Doctor Johnson answered the call of duty and volunteered for active service during the first World War. He enlisted January 4, 1918 in Charleston and was given the rank of Captain in the Medical Corps. After a course of training at several stations in this country, including Camp Jackson at Columbia, he sailed from New York City on the Leviathan on July 8, 1918. The following twelve months were spent on the orthopedic service of several large base hospitals in France. At one time at Base Hospital No. 68 at Mars su Alliex, he had under his treatment 774 sick and wounded without the benefit of assistance from other doctors, nurses or orderlies. This was a monumental task. He devised means of making as many of his fracture cases as possible ambulatory and in this way, many of the patients assisted in the care of others. Evidently his work was done well and with accustomed thoroughness, as I have in my possession copies of letters from Colonel L. O. Tarlton and C. B. Francisco, praising him for his skill and recommending his promotion to Major. It is strange that this promotion was never made. Doctor Johnson returned to this country on July 5, 1919 and was honorably discharged at Camp Dix, New Jersey on August 5, 1919. Soon thereafter he resumed his practice and teaching in Charleston.

Doctor Johnson was a large, heavy set, deep chested, powerful man. He was peculiar and gruff at times, but very courteous in his manners. His face was a peculiar combination of sternness and, at times, fearsomeness, but he had a merry twinkle in his eye, his expression could be soft and he could laugh with a hearty guffaw. Children loved him and, he, them. He prided himself very much on his strength and for exercise he used to throw a heavy anvil around his back yard. My recollection is that he did not use tobacco or indulge in alcoholic beverages.

I recall very clearly his pride in making splints for his patients. He did all of this with his own hands and would trust no one to do it for him. In addition to his work shop at home he kept under his own lock and key a small splint room at the Roper Hospital. No one could go into this room. He delighted in bending cold steel into the necessary shape for an individual case and he told me of some noted authority who had complimented him on being the only man in America who could bend metal in that way without heating.

At college his nickname was "Jumbo" and his feats of physical prowess were many. There is a famous "goat story" concerning which there are numerous versions. One is that while at the University of Virginia he bet a classmate that he could kick a goat in the rear and break its neck. Just as he was preparing to execute the pedal punch, the goat turned, rammed him on the opposite shin and broke his leg. The story goes on to say that Doctor Johnson, still resolute and determined in his purpose further enticed the goat until it charged again. Using his good leg, he hopped behind a tree just in time. The goat rammed the tree, breaking its neck and "Jumbo" collected his bet.

My memory may be distorted concerning this story, but I am sure that I can recall Doctor Johnson's version as he told it to me on request. I was particularly anxious to hear it directly from him. My recollection is that this was an especially large and ferocious animal that in considerable measure had terrorized the neighborhood with various deeds of its strength and ferocity. Doctor Johnson wagered that he could kill the goat with his bare hands, which he did. He told me that the trick was in very precise timing. It was a simple matter to stand still as the goat charged and just as the goat lowered its head for ramming, quickly kick him on the nose with one foot, grasp his horns at the same moment, jerk the head forward, flip the goat over and break its neck. It was my understanding that he had been proclaimed a hero for ridding the community of such an unpleasant and dangerous animal.

Another story that he told me gives still further testimony to his prodigious strength. I do not recall the details clearly, but it seems that he was somewhere in an old or unfinished building aiding in the

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REFERENCES: Spielman, A. D. (1950), N. Y. St. J. Med., 50:2297, Oct. 1. Brown, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb. Jenkins, C. M. (1950), J. Nat. Med. Assn., 42:293, Sept. Cullick, Louise, and Ogden, H. D. (1950), South. Med. J., 43:632, July. Ehrlich, N. J., and Kaplan, M. A. (1950), Ann. Allergy, 8:682, Sept.-Oct.

capture of a criminal or some fugitive from justice. They knew the man was hiding somewhere in the building. Doctor Johnson looked up and saw the man's foot showing through a crack or hole in the ceiling. He jumped up, grasped the man's foot in one hand, supporting his own weight, and held on until others could go up in the loft and capture the criminal.

Another delightful story I recall his telling was of his first automobile, which I understand was the first in the state owned by a doctor. It was one of those early converted buggy affairs with high wheels, chain drive, a small motor under the seat and no top. The rear seat was immediately behind the front seat and faced backward. He would tell how horses would plunge and shy with fright as he approached and he would laugh heartily as he told how guests for their first ride would squeal with excitement and hang on as he turned corners at the reckless speed of perhaps five to ten miles per hour.

An interesting habit of Doctor Johnson's which had its inception with his first car was that he always made sure to write down the license numbers of the cars in front and behind when he parked his own automobile. In this way he would have the number of the car in case his might be damaged.

As has been stated previously, Doctor Johnson was not an operating orthopedic surgeon. By that is meant that he did not operate as much as does the modern orthopedist or as much as some are wont to do. He believed in and he taught conservatism. He decried open operations and was of the opinion that anyone who did not possess sufficient skill to be an orthopedist. In fact, Doctor Johnson belonged to that early school of strap and buckle or harness making orthopedists whose pioneering efforts did so much to develop the specialty but whose methods in many instances have been succeeded by modern means. In time, our prized modalities of today will be relegated into tomorrow's yesterday.

The basic principles he taught were good and his knowledge of anatomy in its relation to bio-mechanics was amazing. He could describe all of the stresses and strains of ligaments and muscles affecting a fracture and influencing its reduction. I remember how he calculated the strength of the patellar tendon when subjected to the strain of supporting the body weight of an individual who sits on a rail fence and leans backward. The long arm of the lever makes the force tremendous if the rail is just behind the knees. He taught the proper way in which to reduce a fracture or dislocation is to reverse the manner in which the injury occurred.

All of his students recall how he required them to make all types of splints with hairpins and small wires. He taught the importance of a careful history and physical examination in making a diagnosis. Unfortunately today the physical examination in so many cases of bone injuries is omitted in favor of the x-rays.

In teaching his classes he referred to special charts that he had prepared. These hung suspended from a wire that extended all around the classroom. The charts were great scrolls that he had prepared himself and many were illustrated. Of particular interest were the hieroglyphich that he used to abbreviate certain words. For example, anoblique line meant "usually" and a figure of eight turned horizontally meant "sometimes." All of these charts have evidently been lost or discarded. He lectured from the charts and, furthermore, he expected students to remember some of them verbatim. At the time of his examinations he frequently asked a question with a numeral at the end of it. This meant that he expected the answer to contain that exact number of words.

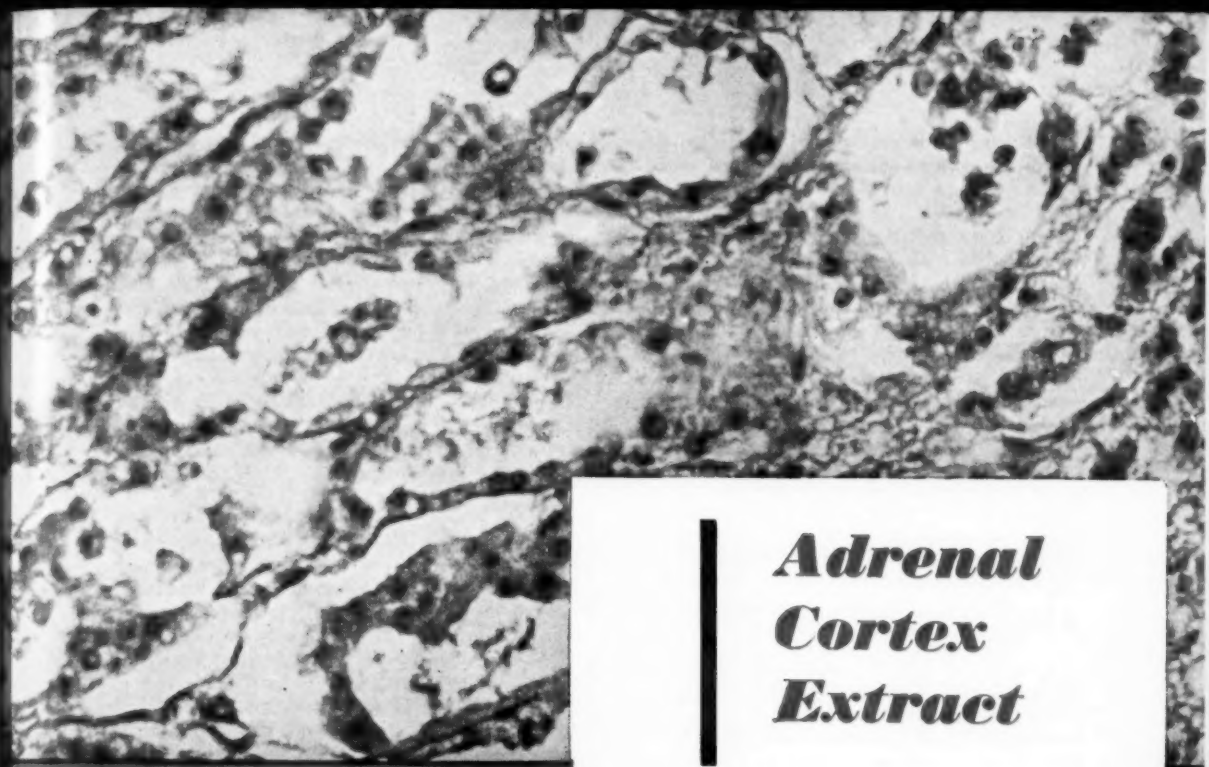
He confided to me that it was his ambition to record all of his lectures on one great scroll, such as a large roll of wrapping paper. He hoped to have this mounted under a trap door concealed in the floor of the rostrum of the lecture room. The entire mechanism could be controlled by electric motors so that at the touch of a button the floor could be made to raise up and present the scroll that in turn could be made to roll forward or backward by electric control. He believed that the convenience of this method would be very desirable and his work and his charts would be preserved indefinitely.

He spent hours making many bizarre splints and braces. Splints were frequently made of metal from the hood of an old automobile. The modern commercial aluminum splint was not known in those days nor were many other pieces of time saving equipment. He used kitchen aluminum ware from Mrs. Johnson's kitchen for many of his splints. He would go to the blacksmith shop for a lot of his work. It was here that he would build windlasses in the ends of his Thomas splints that he used so frequently for traction.

In fairness to the record it should be stated that many of his methods were unnecessarily complicated and often he seemed to prefer the complicated method to some simpler means.

I recall his method of reducing a fractured clavicle by putting the patient's outstretched arms in Thomas splints whose rings abutted each other under one shoulder. The arms were fastened to windlasses in the ends of the splints and as the patient lay supine in bed over a large pillow between his shoulders, the windlasses were tightened gradually. There is no question about reducing the clavicle. The only question is how long the patient could remain in this position and what to do when the splints were removed.

His demonstration of a method of reducing a traumatic dislocation of the hip was equally impressive and dramatic. The patient was placed face downward on a bed with the affected limb hanging over one side, the knee and hip flexed to a right angle and the foot resting on a chair. A heavy weight was suspended



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from the leg just below the knee and the patient was left in this position. As muscle relaxation took place within twenty to thirty minutes the hip snapped back into place. This is a prescribed method of treatment described in text books and is something that should be remembered in cases where anesthesia is contra-indicated. Without disrespect, it follows the same principle of treatment as laid down by Hippocrates who recommended that the patient with a dislocated hip be placed astride a bullock that had fasted for five days on salt and hay. The feet of the patient were bound together under the animal's abdomen and he was then led to water. As the abdomen swelled "the wandering bone was brought back into its socket."

Doctor Johnson developed a most ingenious fracture bed that in many respects was similar to the modern orthopedic table. He made a beautiful and expensive brass model. It was so complicated that no one other than himself knew how to operate it, but it is a great pity that this, along with many other pieces of his equipment, has not been preserved.

It was a revelation and indeed uncanny at times to see some of the things that Doctor Johnson did. His strength and unusual understanding of mechanical prinicples no doubt was responsible for the good results in most cases, but at times he literally seemed to hypnotize patients and make them do as he willed. Doctor Siegling records the case of a negress with a fractured jaw that no one was able to reduce. Doctor Johnson came into the room and in a moment affected the reduction. When asked how it was done he replied that he had inspired such complete confidence that relaxation made the reduction easy. I recall a similar incident relating to a fracture of the upper end of the humerus. He used an ice pick with very little local anesthesia, yet relaxation was complete and he made a perfect reduction.

To avoid surgery, he frequently resorted to the use of an ice pick inserted for leverage between the fragments of a fracture. At times he used a fork when wider leverage was necessary. This was probably an original method with him, as I know of no previous text in which it was recommended. He used this method frequently in supracondylar fractures and to manipulate fractures of the radius and ulna. He dreaded elbow fractures and the possible development of stiff joints and "gun-stock" deformities. I know of no reason for this, for I think his results were good but he may have been a little impatient and manipulated the joints for motion after healing had taken place.

To illustrate the change that has been wrought in orthopedics since I was a student, I remember Doctor Johnson teaching that one should never operate on the knee joint unless absolutely necessary. He emphasized that the knee is the largest joint in the body and, infection, therefore, might be fatal. With modern asepsis and antibiotics, knees are operated on now without hesitancy. He taught that when doing amputations one should be very careful to wash away the sawdust as this could cause infection. Now sawdust is collected and the small bone particles are recognized as being very advantageous in bone grafting surgery. I do not recall ever having seen Doctor Johnson do a bone plating, bone grafting or other commonly performed elective bone operation as is done today. Bone surgery in Charleston in my student days was rather infrequent and wound infections were not uncommon. Doctor William Aimar did a fair amount of bone surgery and was known as "Bloody Bill." Doctor Johnson boasted that he never had a patient to die on the orthopedic service. When such an eventuality seemed likely he transferred the patient to general surgery.

Another phobia of Doctor Johnson's was the dread of a possible medico-legal suit. There is no accounting for this, as never at any time was there ever any threat of such action. It is true that he went to an extreme in protecting himself. It was required of every patient that he operated on to have signed and executed a very formidable and lengthy legal document completely absolving him from blame and responsibility in case of any complication resulting from his treatment. He rigidly refused to render treatment unless these papers were signed and he guarded and concealed them so cleverly that no trace of them has ever been found.

His prescriptions were also characteristic. He would not allow any drug store to print them for him but had them made up himself. His office hours were "until 10:00 A. M., 3:00 P. M., one hour in evenings commencing at dark." Across the top of the prescription was printed "not to be copied, shown, read aloud, told or refilled."

There are few men who will be remembered as vividly as Doctor Johnson. So many amusing anecdotes have been told about him that already his character is legendary. I cannot but help repeat his advice to me when I began my lectures at the Medical College. Among other things he told me to be sure to gain the attention of audiences at the beginning of the lecture. He illustrated by reciting an experience he had once in addressing a meeting of the King's Daughters. He said the meeting was very dry and he knew he would have difficulty in gaining the attention of that particular group of staid, older ladies who were present. He began his talk by saying, "Once when I was in a whore house ——." Then came a long pause. Immediately the air was electrified, he had their attention and went on to explain that he was called there on an obstetrical problem and he used this to build the basis for his subsequent remarks.

The following story illustrates his sense of humor and capriciousness. Doctor Johnson, at one time, overheard a very braggadocious salesman of the B. H. Worthen Arms Company boastfully describing his ability as a sharpshooter. Doctor Johnson sidled over

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to the salesman and asked him if he had ever shot bees. The salesman replied that he had not, but he was sure he could if anyone could. Doctor Johnson wagered that he was the better shot of the two. They retired to a pasture and took turns shooting the bees. Doctor Johnson could hit them, but the sharpshooter could not. The secret was that he had taken his small son along and every time it was his turn to shoot, the child would chuck a pebble at a bee and he shot them as they paused momentarily in the air.

And there is the story of the steam heated lunch box. Doctor Joe Waring told me of an experience that he had once when he was to accompany Doctor Johnson on an automobile trip. He asked Doctor Johnson where and how they would have lunch. Doctor Johnson told him that he had it all arranged. He had devised an apparatus whereby the box of lunch was screwed into the radiator of the car and was kept warm in this way.

A final example of the zeal of his work, the unselfishness of his nature and his desire to relieve suffering humanity, is the story of one of his little colored patients, Eddie Richardson, as told to me by Mrs. Johnson. Eddie was a pitiful case with such extremely deformed limbs he was unable to walk. He had "legs like a snake" and large calluses on his hands and stomach. Doctor Johnson spent $10,000 in the rehabilitation of this child. He operated on him a number of times and grafted some bone from a sheep. The boy finally recovered. He was able to get about so well that he could dance the Charleston. His implicit faith in Doctor Johnson was such that after his recovery he returned and in all seriousness asked to be made white. Eddie Richardson is now grown and normal. He is married and has several children.

If, in this sketch, I have given the idea that this paper is a characature of this noble man, I am sorry. That is not my purpose. Doctor Johnson was a great and good man devoted to humanity, devoted to his family and devoted to his God. He had a host of friends and those who knew him best loved him most.

He died suddenly of a heart attack on April 14, 1934, at the age of 63. I attended his funeral at his beloved Grace Episcopal Church that could not accommodate the vast throng of sorrowing friends and relatives who came to pay their last respects. There were many colored mourners, as well as whites. The esteem in which he was held by the grateful negroes of Charleston was further evidenced by a communication to the News and Courier shortly after his death. It was written by two colored citizens "in behalf of the negroes of Charleston" as a tribute to the memory of William Henry Johnson.

That he was eccentric there can be no doubt. Mrs. Johnson told me that Billy Smith had made the remark, "He is a genius and a crank but I like him." She added, "It may be so, but I loved him." As an example of his fidelity to Mrs. Johnson he told her the only epitaph he wanted on his tomb was, "He married Lottie."

I hope that you have enjoyed this paper as much as I have enjoyed its preparation.

In closing, I would like to quote from the resolutions as a memorial to Doctor Johnson, drawn up and presented to the Medical Society of South Carolina by Doctor Robert S. Cathcart, Chairman of the Committee appointed for this purpose.

"He practiced his profession for thirty-four years and his ethical standing was never questioned; he drew his patients from all walks of life and was as ready to aid the humble negro as the man of wealth. He was a pioneer in many lines of medicine and the medical students who came under his influence as a teacher left his classes with enlarged visions of the kind of service they could render suffering humanity.

Doctor Johnson was a deeply religious man and although he did not force his convictions on others, his intimates were aware of this basic quality in his nature. As an evidence we would quote from a prayer written by him to a young boy:

"Let us pray our prayer together:

Attune Thyself O Lord to the vibrations of the souls of Thy audacious supplications, and

Grant us those things which are best for us.

Teach us what Thou wouldst have us do.

Give us the desire and power to accomplish the same, as by right we should.

Vouchsafe to us a full measure of ability, happiness, health, prosperity, temperance, faith, hope, charity, humility, industry, aggressiveness, self-respect and contentment as is good for us, we ask in the name of Thy holy Son, Jesus Christ, Amen.

This may sound preachy but it is not. It is but a vibration from chordae tendinae (heart strings) which are in unison with yours."

Doctor Johnson was an extremely modest man and would never seek the praise of his fellows, and so, to live each day to the fullest, to deal honestly with all men, to be loyal to his friends, to deal gently with the erring and give of his wisdom to those needing help, to love all men and rejoice in every advance made by men in his beloved profession—this was William Henry Johnson's creed and by it he lived and will always be remembered by his friends."

Presented before The Columbia Medical Club, Columbia, South Carolina, by Doctor Austin T. Moore, January 15, 1951.

DEATHS

WILLAM EUGENE KING

Dr. William Eugene King, 63, of Aynor, died suddenly on May 27, at his summer home at Murrell's inlet. He had been in failing health for the past few years.

A native of Florence County, Dr. King received his education at Furman University and the Medical College of South Carolina. Following the completion of his medical training he opened an office in Aynor where he carried on an extensive general practice up until the time of his retirement.

Surviving Dr. King are his widow, a son and two daughters.

CORRESPONDENCE

Julian P. Price
Secretary, Medical Association
105 W. Cheves Street
Florence, S. Carolina
My Dear Mr. Price:

To keep military Reserve Medical Officers of the Armed Forces, Army, Navy and Air Force posted on the latest developments in the Field of Medical Science, the Second Annual Medico-Military Symposium will be held at the U. S. Naval Hospital, Philadelphia, Pennsylvania from 22-27 October 1951.

Commodore Richard A. Kern, MC, USNR, Professor of Medicine, Temple University School of Medicine and Chairman of the Symposium General Committee will preside over the opening session and introduce the speakers as listed on copies of enclosed preliminary schedule for Monday afternoon 22 October 1951.

It is urged that officers make hotel reservations well in advance, since no government housing facilities will be available. The final session of the Symposium will be held Saturday morning 27 October, leaving the afternoon free for officers to attend the Penn-Navy football game.

Would you be so kind as to publish the invitation to this medical meeting in your journal.

Thanking you very kindly, I remain

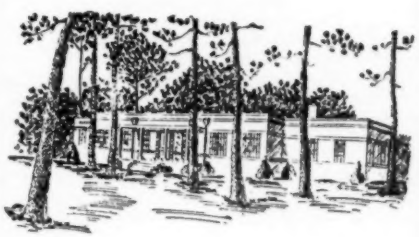
Sincerely yours,
M. H. Porterfield
Captain, MC, USN
Medical Reserve Program Officer

NEWS ITEMS

The sixteenth annual assembly of The United States Chapter of The International College of Surgeons will be held in Chicago on September 10th through the 13th, 1951, with headquarters at the Palmer House.

An excellent program has been arranged. Prominent surgenos from the United States and other countries will participate. Scientific sessions will be held by

Carolina Rest Home Hospital



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all specialty sections of the United States Chapter.

The annual banquet will take place on Wednesday evening, September 12. Mr. Lawrence Abel, F.R.C.S. (Eng.). of London, will be the principal speaker.

The assembly will conclude with the convocation, to be held in the Civic Opera House on the evening of September 13. Senator Estes Kefauver will deliver an address on "The America of Tomorrow."

Hotel reservations may be arranged by writing to the Housing Division, Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois.

COURSES IN EXFOLIATIVE CYTOLOGY (CANCER DETECTION)

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September 17—December 14, 1951
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These two courses will be open to a limited number of physicians and technicians. They will cover the cytology of the female genital, gastrointestinal, respiratory, and urinary tracts, as well as exudates. Instruction in laboratory procedures related to cytology will also be given. Tuition for each course is $300.00.

Arrangements for shorter periods of instruction covering all or certain applications of exfoliative cytology may be made for those physicians who cannot come for the entire three months. Applications may also be submitted for the study of our cytologic material for varying lengths of time during the rest of the year, except for July and August. The tuition in these cases will depend upon the length of time desired for training.

Instruction will be given by Dr. George N. Papanicolaou, Dr. John F. Seybolt and their associates.

For further information and application blanks, write to:

Dr. John F. Seybolt
Department of Anatomy
Cornell University Medical College
1300 York Avenue
New York 21, N. Y.